# BREAST CANCER: RACE FOR THE CURE

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# HEARING

BEFORE THE

## SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

OF THE

## SELECT COMMITTEE ON AGING
## HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

MAY 16, 1990

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# CONTENTS

## MEMBERS' OPENING STATEMENTS

Page

Chairman Edward R. Roybal ..... 1
Mary Rose Oakar ..... 5
Ralph Regula ..... 9
Wayne Owens ..... 13
John T. Myers ..... 15
Ike Skelton ..... 16
Thomas J. Downey ..... 16
James H. Bilbray ..... 19
Dennis M. Hertel ..... 19
Norman Sisisky ..... 20
Richard T. Schulze ..... 21

## CHRONOLOGICAL LIST OF WITNESSES

Marilyn Quayle, Wife of the Vice President of the United States and Honorary Co-Chairman, 5K Race For The Cure ..... 25
Hon. Barbara F. Vucanovich, a representative from the State of Nevada ..... 27
Nancy G. Brinker, Founding Chairman, The Komen Foundation for the Advancement of Breast Cancer Research, Education and Training ..... 31
Lynda Carter, Actress, and Co-Chair, 5K Race for the Cure ..... 35
Deborah I. Dingell, Chair of the Board of Directors, National Women's Health Resource Center ..... 38
Isabel Hammond, Executive Director, American-Italian Foundation for Cancer Research, New York, NY ..... 50
Samuel Broder, M.D., Director, National Cancer Institute, Bethesda, MD ..... 58
Marc E. Lippman, M.D., Director, Vincent T. Lombardi Cancer Research Center, Georgetown University Medical Center, Washington, DC ..... 73
Maureen M. Henderson, M.D., Head, Cancer Prevention Research Program, The Fred Hutchinson Cancer Research Center, Seattle, WA ..... 79
Harvey Kushner, Advocate of Breast Cancer Victims, and Chairman, Board of Directors, Breast Cancer Advisory Center, Kensington, MD ..... 94

## APPENDIX

Comments of the National Women's Health Network ..... 119
"Finding a Lump in Your Breast," American Cancer Society pamphlet ..... 123

# BREAST CANCER: RACE FOR THE CURE

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WEDNESDAY, MAY 16, 1990

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE,
*Washington, DC*

The subcommittee met, pursuant to call, at 10:20 a.m., in Room 311, Cannon House Office Building, Hon. Edward R. Roybal (chairman of the subcommittee) presiding.

Members present: Representatives Roybal, Oakar, Skelton, Hertel, Sisisky, Wayne Owens, Regula, Bentley, Downey, Bilbray, Morella, and Myers.

Staff present: Kathleen Gardner Cravedi, Staff Director; Melanie Modlin, Assistant Staff Director; and Mark Benedict, Minority Staff Director.

## OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

Chairman ROYBAL. The committee will now come to order.

The subject of today's hearing is of great concern to women, particularly elderly women. We know that about 43,000 people will die of breast cancer in 1990; over one-quarter of those that die will be over the age of 75. Women are not the only victims, as we all know. It affects their husbands, their children, their loved ones. Breast cancer is something that we, as Americans, must immediately address ourselves to. We should start thinking about putting more money into research, into those facilities that would make possible a vast reduction in the incidence of this problem.

We have held two previous hearings on breast cancer in the last 6 years. Both, incidentally, were requested by my colleague Mary Rose Oakar, who sits here to my right—one who has been a great leader in the Congress of the United States on this critical issue. Every committee, I think, has to have someone who keeps pushing the chairman, until finally the chairman agrees to do something. Well, she was responsible for the previous hearings; and may I state that I firmly believe that she is responsible for the hearing that we are holding today.

We have great interest in the problems of health in general. And sometimes it is not possible to hold hearings on every particular issue. But this is of great importance.

We found in the previous hearings that if breast cancer were detected earlier, we could reduce deaths by 30 to 40 percent. That means saving approximately 10,000 lives every year. Despite these findings, however, breast cancer deaths have continued to increase in the past 6 years. In 1985, we found that 1 in 11 American women would contract breast cancer in her lifetime. Now it will affect 1 in every 9. About 150,000 new cases will be diagnosed this year alone, and that is up from 120,000 in 1985. So we look at these statistics and we find that we are not making any progress.

The purpose of this hearing is to find out why. What recommendations can we make? What can we do to remedy the situation?

I ask unanimous consent to include in the record the balance of my opening statement.

Without objection, that will be the order.

[The prepared statement of Mr. Roybal, and the bill, H.R. 3251, follow:]

OPENING STATEMENT
OF
THE HONORABLE EDWARD ROYBAL, CHAIRMAN,
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE
OF THE
U.S. HOUSE SELECT COMMITTEE ON AGING
ON
"BREAST CANCER: RACE FOR THE CURE"

MEMBERS OF THE SUBCOMMITTEE. LADIES AND GENTLEMEN. CANCER IS OF VITAL CONCERN TO AMERICANS OF ALL AGES THROUGHOUT AMERICA AND TO PEOPLE OF ALL COUNTRIES WORLDWIDE. NO CURE EXISTS FOR THIS DEADLY AND FRIGHTENING DISEASE.

CANCER IS ESPECIALLY DEVASTATING FOR THE ELDERLY. PERSONS OVER AGE 54 MAKE UP OVER 80% PERCENT OF ALL CANCER DEATHS, AND PEOPLE OVER THE AGE OF 65 ACCOUNT FOR MORE THAN HALF OF ALL SUCH DEATHS. BREAST CANCER -- THE SUBJECT OF TODAY'S HEARING -- IS OF PARTICULAR CONCERN TO OUR ELDERLY WOMEN -- FOR ABOUT 43,000 WOMEN WILL DIE OF BREAST CANCER IN 1990. OVER ONE-QUARTER WILL BE OVER THE AGE OF 75.

PRACTICALLY EVERY FAMILY HAS BEEN AFFECTED BY THIS CRIPPLING DISEASE. IT IS NOT ONLY THE WOMAN WHO IS VICTIMIZED, I MIGHT ADD, IT IS ALSO THEIR HUSBANDS, THEIR CHILDREN, THEIR LOVED ONES.

THIS SUBCOMMITTEE HAS HELD TWO PREVIOUS HEARINGS ON BREAST CANCER IN THE LAST SIX YEARS. BOTH OF THOSE HEARINGS AS WELL AS TODAY'S WERE CALLED AT THE REQUEST OF MY DISTINGUISHED COLLEAGUE, THE HONORABLE MARY ROSE OAKAR, WHO HAS BEEN ONE OF THE GREAT LEADERS IN THE CONGRESS IN SENSITIZING THE AMERICAN PUBLIC OF THE NEED TO COMBAT AND CURE BREAST CANCER. SO, I AM PLEASED TO JOIN HER IN CALLING FOR THIS INQUIRY TODAY. IN PREVIOUS HEARINGS, WE FOUND THAT IF BREAST CANCER WERE DETECTED EARLIER, WE COULD REDUCE DEATHS FROM THE DISEASE BY 30 TO 40% -- SAVING 10,000 LIVES ANNUALLY. WE ALSO FOUND THAT IF DETECTED EARLIER, TREATMENT FOR BREAST CANCER NEED NOT BE SO RADICAL -- SO DEVASTATING PHYSICALLY TO A WOMAN. MOST IMPORTANTLY, I BELIEVE, WAS OUR FINDING THAT THE COMBINATION OF BREAST SELF-EXAMINATION, REGULAR PHYSICAL EXAMS, AND MAMMOGRAPHY CAN BE AS EFFECTIVE IN REDUCING BREAST CANCER MORTALITY AS THE PAP SMEAR HAS BEEN IN CURBING DEATHS DUE TO UTERINE CANCER. SINCE THE INTRODUCTION OF THE PAP SMEAR 40 YEARS AGO, THE DEATH RATE FROM UTERINE CANCER HAS DECLINED MORE THAN 70%. DESPITE THESE FINDINGS, BREAST CANCER DEATH RATES HAVE CONTINUED TO INCREASE IN THE PAST SIX YEARS WITH NO EXPECTED DECREASE IN SIGHT. BREAST CANCER IS NOW AN EPIDEMIC IN THE UNITED STATES. IN 1985, WE FOUND THAT 1 IN 11 WOMEN WILL CONTRACT BREAST CANCER, NOW IT WILL AFFECT ONE IN EVERY 9 WOMEN. AND BREAST CANCER IS INCREASING IN INCIDENCE. ABOUT 150,000 NEW CASES WILL BE DIAGNOSED THIS YEAR ALONE, UP FROM 120,000 IN 1985.

IN PART, THE INCREASE IN BREAST CANCER DEATHS CAN BE ATTRIBUTED TO THE UNDERUTILIZATION OF EARLIER DETECTION. IT IS UNCONSCIONABLE TO LEARN THAT MAMMOGRAPHY SCREENING IS STILL LARGELY UNDERUTILIZED IN OUR COUNTRY. THE SUBCOMMITTEE HAS FOUND THAT MANY WOMEN DO NOT RECEIVE THE BENEFIT OF DETECTION OR NEW PREVENTATIVE TECHNOLOGY BECAUSE OF THEIR LACK OF AWARENESS, OR BECAUSE THEY CANNOT AFFORD THE PROCEDURE, OR BECAUSE IT IS UNAVAILABLE IN THEIR AREA.

IT IS VITAL THAT WE INCREASE THE PUBLIC AWARENESS OF THE NEED FOR EARLY BREAST CANCER SCREENING AND PROMOTE POLICIES WHICH MAKE SUCH SCREENING MORE AFFORDABLE AND AVAILABLE FOR ALL. DOING SO WILL SAVE THOUSANDS OF LIVES ANNUALLY. WE MUST ALSO COME TO GRIPS WITH THE FACT THAT EARLY SCREENING, DETECTION AND TREATMENT OF BREAST CANCER IS NOT A CURE. WE STILL NEED TO DEVELOP THAT MAGIC BULLET.

AT OUR HEARING, WE WILL HEAR FROM SOME OF THE FOREMOST RESEARCHERS IN BREAST CANCER. THEY WILL DISCUSS PROMISING DEVELOPMENTS, SUCH AS A LINK BETWEEN DIETARY FAT AND HIGHER INCIDENCE OF BREAST CANCER. INTERESTINGLY, WOMEN IN ASIA, WHOSE DIETS ARE LOWER IN FAT THAN OURS, HAVE A MUCH LOWER RISK OF CONTRACTING THE ILLNESS. YET, WHEN THESE WOMEN MOVE TO WESTERN NATIONS, THEIR DIETS CHANGE AND THEY ARE MUCH MORE LIKELY TO CONTRACT BREAST CANCER. IT'S AN OUTRAGE WE AREN'T FUNDING DEFINITIVE RESEARCH ON THIS CRITICAL CORRELATION. IT IS RESEARCH LIKE THIS THAT CAN LEAD TO THE PREVENTION AND ULTIMATELY A CURE FOR THIS DREADED DISEASE.

TODAY, WE ARE PLEASED TO HAVE WITH US THE HONORABLE CHAIRPERSON OF THE "RACE FOR THE CURE," A FIVE-KILOMETER RUN/WALK TO TAKE PLACE JUNE 16, 1990 IN WASHINGTON, D.C. THE RACE AIMS TO MAKE BREAST CANCER AN ISSUE OF NATIONAL CONCERN AND HAS THE GOAL OF RAISING PRIVATE FUNDS FOR EFFORTS TO PREVENT, DETECT AND TREAT BREAST CANCER, AS WELL AS TO SUPPORT BASIC RESEARCH. THE CHAIRPERSON OF THIS EVENT IS A WORTHY SPOKESPERSON FOR THIS WORTHY ISSUE. SHE IS A WOMAN AT RISK -- THE DAUGHTER OF A MOTHER WHO DIED OF BREAST CANCER AND THE WIFE OF THE CURRENT VICE-PRESIDENT OF THE UNITED STATES. SHE IS THE MOTHER OF 3 CHILDREN WHO I AM SURE HOPE SHE WILL NOT INHERIT HER MOTHER'S MEDICAL LEGACY. SHE HAS CHOSEN TO HELP OTHER FAMILIES BY SPEAKING ON BEHALF OF THOSE WHO ARE SIMILARLY SITUATED, BY ALERTING AMERICANS TO TAKE RESPONSIBILITY IN THE RACE TO END THIS KILLING DISEASE. WE LOOK FORWARD TO THE TESTIMONY OF MRS. MARILYN QUAYLE.

NEXT, WE WILL HEAR FROM THOSE WHO HAVE BEEN PRIVATELY FIGHTING THE BREAST CANCER BATTLE AND WHOSE NOTEWORTHY EFFORTS SHOULD BE REPLICATED IN EVERY COMMUNITY IN AMERICA. WE ARE DELIGHTED TO HAVE LYNDA CARTER, AN ACTRESS AND NOTED ADVOCATE FOR BREAST CANCER PREVENTION, WHO IS CO-CHAIRING THE "RACE FOR THE CURE." SHE WILL BE JOINED BY DEBBIE DINGELL, WIFE OF THE CHAIRMAN OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE, WHO WILL DETAIL HER EFFORTS TO STIMULATE GREATER PUBLIC AWARENESS OF BREAST CANCER THROUGH HER POSITION AS DIRECTOR OF THE NATIONAL WOMEN'S HEALTH RESOURCE CENTER AT COLUMBIA HOSPITAL FOR WOMEN. AND, ISABEL HAMMOND, THE EXECUTIVE DIRECTOR OF THE AMERICAN-ITALIAN FOUNDATION FOR CANCER RESEARCH, WILL DETAIL THE INTERNATIONAL WORK IN BREAST CANCER SO VITAL IN OUR SEARCH FOR A CURE.

LASTLY, WE WILL HEAR FROM NOTED RESEARCHERS. OUR DISTINGUISHED PANEL INCLUDES THE DIRECTOR OF THE NATIONAL CANCER INSTITUTE, THE FORMER DIRECTOR OF THE NATIONAL CANCER INSTITUTE'S BREAST CANCER SECTION, THE HEAD OF A CANCER PREVENTION TREATMENT PROGRAM AND THE HUSBAND OF ONE OF OUR COUNTRY'S MOST ARDENT ADVOCATES OF BREAST CANCER WHO RECENTLY DIED OF THE DISEASE HERSELF. THEY WILL DETAIL FOR US THE ONGOING WORK OF THE NATIONAL CANCER INSTITUTE IN THE AREA OF BREAST CANCER, WHAT BARRIERS EXIST IN INCREASING USAGE OF MAMMOGRAPHY, WHAT STUDIES AND RESEARCH REMAIN UNFUNDED AND UNDERFUNDED, AND WHAT EFFORTS ARE UNDERWAY TO FIND A CURE AND NOT JUST TREAT BREAST CANCER. THEY WILL POINT TO PROMISING DEVELOPMENTS THAT MAY REQUIRE IMMEDIATE CONGRESSIONAL ATTENTION.

I THINK THAT IT WOULD BE IMPORTANT TO PAY TRIBUTE TO THE FORMER CHAIRMAN OF THIS SUBCOMMITTEE. I KNOW HE WOULD LOVE TO BE HERE TODAY. HE WAS ONE OF THE ORIGINAL SPONSORS OF THE NATIONAL CANCER INSTITUTE AND HE AND I FOUGHT TO MAKE HOME CARE AVAILABLE TO ALL CHRONICALLY ILL INCLUDING THOSE WITH CANCER. I WILL CONTINUE TO WORK TO MAKE THAT DREAM OF COMPREHENSIVE HEALTH CARE A REALITY. AS MOST OF YOU HERE KNOW, HE SPENT A GREAT DEAL OF HIS 50 YEAR CONGRESSIONAL CAREER TRYING TO FIND A CURE FOR THIS KILLING DISEASE WHICH EVENTUALLY TOOK HIS LIFE AND THE LIFE OF HIS WIFE. LET US RECOMMIT OURSELVES TO HIS RACE FOR THE CURE.

THANK YOU. I LOOK FORWARD TO TODAY'S TESTIMONY.

101st CONGRESS
1st Session

# H. R. 3251

To authorize an additional $25,000,000 for the National Cancer Institute to conduct certain research on breast cancer.

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IN THE HOUSE OF REPRESENTATIVES

SEPTEMBER 12, 1989

Ms. OAKAR introduced the following bill; which was referred to the Committee on Energy and Commerce

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# A BILL

To authorize an additional $25,000,000 for the National Cancer Institute to conduct certain research on breast cancer.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,* That in addition to the sums authorized to be appropriated for the National Cancer Institute under sections 301 and 408 of the Public Health Service Act for fiscal year 1990, there is authorized to be appropriated for such fiscal year to the National Cancer Institute $25,000,000 for breast cancer research other than research which involves treatment or clinical trials.

Chairman Roybal. I now recognize Mary Rose Oakar.

## STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. Oakar. Thank you, Mr. Chairman.

I want to personally thank you for having this hearing. I know how busy your schedule is, and other Members' schedules. And this is the third hearing that the Select Committee on Aging has had on this issue, and we were the first committee to ever have a hearing on breast cancer. So my personal gratitude to you, Mr. Chairman, in particular, for your leadership on this and other issues.

Mr. Chairman and my colleagues, we are really reaching a crisis with respect to this disease that affects, as the chairman said, 1 out of 9 women; when we first had our hearing it was 1 out of 11 in 1984—now it's 1 out of 9. One woman, every 13 minutes, finds out she had breast cancer. We will have 142,000 women this year find out that they have breast cancer—a few men, but mostly women.

Because of the Vietnam War, we lost 57,000 men and women. During that same period—we lost 330,000 women to breast cancer.

So we are in a crisis, and yet there hasn't been the same kind of zeal to do something about this issue as we see in other issues—and we do the right thing, I think, in other issues. Just to make a quick comparison, it was interesting to me that with respect to AIDS, we had $1.6 billion and, this year, the Budget Committee recommended 700,000 more dollars for AIDS research, which affects about 1 in every thousand individuals in this country—and I support that. However, we have been trying for sometime to get an increase of about $25 million more for breast cancer research. In terms of pure research, we only spend about $19 million in that area. It has at times has fallen on deaf ears.

We also would like to see every woman in this country be able to have access to a mammogram and to be aware that that is important to have access to that. That's why we have tried—my colleague, Barbara Vucanovich, myself, and others—have tried to make sure that Medicaid and Medicare cover mammography as a benchmark for what we want private insurers to do; because we know we can save money and can save lives.

Mr. Chairman, I am especially gratified by our superb witnesses today, who will be led off by the Second Lady of our country, Marilyn Quayle.

Marilyn's own mother passed away with breast cancer. So I respect Marilyn's zeal for this issue—she knows that she can't do anything for her own mother just as we can't now do anything for the late, great Rose Kushner, who did so much to inspire many of us; Nina Hyde of The Washington Post, who did so much to inspire us, and others.

But the fact is we have to think of the future, and that is why Marilyn is here, to talk about a very important event that will be coming up where all women in this country can participate—to show the Congress, the Administration, and the American people that this is truly a crisis.

I want to thank Mrs. Quayle—I know this is a very busy day—for her coming today; and thank my colleagues as well.

I ask unanimous consent that my remaining remarks be submitted for the record.

Chairman ROYBAL. Without objection, that will be the order.

[The prepared statement of Ms. Oakar follows:]

Statement of Representative Mary Rose Oakar
before the
House Aging Subcommittee on Health and Long-Term Care
May 16, 1990

MR. CHAIRMAN, I THANK YOU FOR HONORING MY REQUEST BY CALLING THIS HEARING TODAY AND CONTINUING THE TRADITION OF LEADERSHIP THAT THIS SUBCOMMITTEE HAS ESTABLISHED IN ADVOCACY OF THE CONCERNS OF THE VICTIMS OF BREAST CANCER -- A DISEASE FOR WHICH RISK INCREASES WITH AGE. I AM PLEASED TO JOIN WITH YOU TO HEAR TESTIMONY FROM A WIDE RANGE OF DYNAMIC INDIVIDUALS WHO ARE, INVOLVED IN EFFORTS TO BRING ABOUT A CURE FOR BREAST CANCER. I AM ESPECIALLY PLEASED TO WELCOME THE WIFE OF THE VICE-PRESIDENT OF THE UNITED STATES, MRS. MARILYN QUAYLE, WHOSE DEVOTION TO THE PROMOTION OF BREAST CANCER AWARENESS AMONG AMERICAN WOMEN HAS BEEN FANTASTIC. MRS. QUAYLE IS HERE TODAY AS THE NATIONAL SPOKESPERSON FOR A VERY IMPORTANT UPCOMING EVENT -- THE 5K "RACE FOR THE CURE" SPONSORED BY THE NINA HYDE BREAST CANCER CENTER, THE SUSAN G. KOMEN FOUNDATION, AND HALLMARK, INC. I WILL LET HER EXPLAIN THE DETAILS OF THIS EVENT, BUT I AM HAPPY TO BE INVOLVED IN THE ORGANIZATION AND PROMOTION OF THIS "RACE FOR THE CURE," AND I AM VERY HONORED THAT MRS. QUAYLE CHOSE TO BE HERE TODAY TO KICK-OFF THIS WONDERFUL EVENT. HER WORK WILL HOPEFULLY SAVE MANY LIVES.

"A RACE FOR THE CURE" IS THE THEME OF TODAY'S HEARING, AND FOR THOUSANDS OF AMERICAN WOMEN, THIS IS A RACE FOR THEIR LIVES. THOSE WHO WILL TESTIFY TODAY ARE, EITHER DIRECTLY OR INDIRECTLY, INVOLVED IN EFFORTS TO FIND A CURE FOR BREAST CANCER. SOME VERY DYNAMIC LEADERS IN THIS RACE ARE HERE TODAY, AND MANY MORE THAT WE WOULD LIKE TO RECOGNIZE, SUCH AS THE AMERICAN CANCER SOCIETY AND THE ONCOLOGY NURSES. I HAVE A SPECIAL PLACE IN MY HEART FOR THESE NURSES, BECAUSE OF ALL MEDICAL PROFESSIONALS THEY SPEND THE MOST QUALITY TIME WITH THE VICTIMS WE WILL TALK ABOUT TODAY. THEIR EXPERTISE IS TOO OFTEN UNDERVALUED.

THE INCIDENCE OF BREAST CANCER HAS REACHED EPIDEMIC PROPORTIONS IN OUR NATION. THIS KILLER WILL TAKE THE LIVES OF 43,000 WIVES, DAUGHTERS, SISTERS, MOTHERS, AND GRANDDAUGHTERS THIS YEAR. IT WILL KILL THEM SLOWLY, PAINFULLY; IT WILL ROB THEM OF THEIR SECURITY, THEIR DIGNITY, THEIR PRECIOUS YEARS OF MOTHERHOOD. THIS KILLER WILL PHYSICALLY MUTILATE THEM AND IT WILL TAKE THEIR MONEY AS WELL. IN MANY CASES IT WILL STEAL THEIR LIFE SAVINGS AND IMPOVERISH THEIR LOVED ONES. IN 1990, BREAST CANCER WILL STRIKE 142,000 WOMEN IN THE UNITED STATES AND 43,000 WILL DIE OF THIS DISEASE. EVERY THIRTEEN MINUTES AN AMERICAN WOMAN IS DIAGNOSED WITH BREAST CANCER. IN 1961, ONE IN EVERY TWENTY AMERICAN WOMEN WERE DIAGNOSED WITH BREAST CANCER, NOW IT IS ONE IN EVERY NINE. ACCORDING TO A RECENT STUDY BY THE FEDERAL CENTERS FOR DISEASE CONTROL, THE DEATH RATE FOR BREAST CANCER VICTIMS HAS INCREASED 24 PERCENT BETWEEN 1979 AND 1986.

IT IS NOT ENOUGH TO EMPHASIZE PUBLIC EDUCATION AND EARLY DETECTION OF THE DISEASE, ALTHOUGH THIS HAS SAVED OR PROLONGED

MANY LIVES. WHAT IS NEEDED IS A CURE. MOST WOMEN DETECT THEIR OWN SYMPTOMS, STILL NEARLY A FOURTH OF THOSE DIAGNOSED WILL DIE. THIS DISEASE CUTS ACROSS ALL SOCIAL AND ECONOMIC BOUNDARIES.

MY CONCERN IS THAT MORE MONEY MUST BE MADE AVAILABLE THIS YEAR TO BOLSTER THE NATIONAL CANCER INSTITUTE'S EFFORTS TO FIGHT THE KILLER, BREAST CANCER. INCREASES FOR BREAST CANCER AT NCI OVER THE LAST THREE YEARS HAVE BARELY KEPT PACE WITH INFLATION. AS WE WILL HEAR FROM SOME OF OUR EXPERT WITNESSES TODAY, SIGNIFICANT NEW WORK IS NOW UNDER WAY AT THE NATIONAL CANCER INSTITUTE. YET MANY OF THE MOST PROMISING NEW DEVELOPMENTS FOR BASIC RESEARCH AND CLINICAL TRIALS WILL NOT BE PURSUED THIS YEAR, BECAUSE OF A LACK OF FUNDING. NEW MONEY IS NEEDED TO PURSUE NEW RESEARCH WITHOUT JEOPARDIZING THE EXCELLENT WORK THAT IS CURRENTLY UNDERWAY AT THE INSTITUTES.

SOME MINOR PROGRESS HAS BEEN ACHIEVED IN THE SEARCH FOR A CURE BUT MANY NEW LEADS CANNOT CURRENTLY BE EXPLORED. MOST OF THE $77 MILLION BUDGETED IN FY 1989 FOR BREAST CANCER AT THE NATIONAL CANCER INSTITUTE IS DIRECTED TO DETECTION, TREATMENT, PREVENTION, AND EPIDEMIOLOGY. THIS FUNDING IS ESSENTIAL. YET, RELATIVELY LITTLE IS LEFT FOR BASIC RESEARCH AND ETIOLOGY. ONLY $17 MILLION WILL BE SPENT THIS YEAR AT NCI ON BASIC RESEARCH. TO ADEQUATELY FOLLOW UP ON LEADS TO A POSSIBLE CURE, AT LEAST $25 MILLION IN ADDITIONAL FUNDING, EARMARKED TO BASIC RESEARCH, IS NEEDED. THIS AMOUNT WAS RECOMMENDED TO ME BY THE LATE MRS. ROSE KUSHNER, A VERY DEAR FRIEND AND CONFIDANTE, FORMER MEMBER OF THE NATIONAL CANCER ADVISORY BOARD AND WIDELY ACCLAIMED CHAMPION OF THE RIGHTS OF CANCER PATIENTS. I RECEIVED SUPPORT FROM EXPERTS BOTH INSIDE AND OUTSIDE OF THE CANCER INSTITUTE THAT $25 MILLION COULD EASILY BE PUT TO PRODUCTIVE USE WITHOUT DUPLICATION OF CURRENT INITIATIVES. WE CAN DO MORE TO STUDY WHY THERE IS A GENETIC PREDISPOSITION TO BREAST CANCER. RECENTLY DISCOVERED -- THE PRESENCE OF CERTAIN ENZYMES IN BENIGN TUMORS MAY INDICATE THE LIKELIHOOD THAT CANCER WILL FOLLOW. WE MUST FOCUS MORE ON THE MOLECULAR ORIGINS OF MALIGNANCY -- WHY DOES A NORMAL CELL BECOME MALIGNANT? I INTRODUCED HR 3251, WITH 53 CURRENT HOUSE COSPONSORS, WHICH WOULD PROVIDE THE NATIONAL CANCER INSTITUTE WITH THIS NEEDED BOOST. EDUCATION AND EARLY DETECTION ARE NOT ENOUGH. WE MUST FIND A CURE.

I WOULD LIKE TO SEE SIGNIFICANT INCREASES IN ALL AREAS OF BREAST CANCER RESEARCH. THE BUDGET OFFICE AT NCI HAS INFORMED ME, THAT IF THE NCI WERE TO GET ITS BY-PASS REQUEST THIS YEAR, AN ADDITIONAL $31 MILLION WOULD GO TO BREAST CANCER RESEARCH. OTHER EXPERTS HERE TODAY WILL TESTIFY THAT EVEN THIS AMOUNT IS INADEQUATE. WE HAVE ALSO LEARNED THAT, THIS YEAR, ONLY 26% OF THE NCI BREAST CANCER GRANT REQUESTS THAT HAVE BEEN APPROVED THROUGH THE PEER REVIEW PROCESS WILL RECEIVE ANY MONEY -- BECAUSE OF A LACK OF FUNDS.

THE ALLIANCE FOR AGING RESEARCH RECOMMENDATIONS, BY MY URGING, WERE ENDORSED IN THE PEPPER COMMISSION'S RECENT REPORT WITH OVERWHELMING ACCEPTANCE. THEY SUGGEST THAT AT LEAST $30 MILLION IN ADDITIONAL FUNDING SHOULD BE ALLOCATED BY CONGRESS THIS YEAR FOR BREAST CANCER RESEARCH. MORE STUDY IS NEEDED ON NEW EVIDENCE OF POSSIBLE LINKS BETWEEN ALCOHOL CONSUMPTION AND BREAST CANCER. THE RELATIONSHIP BETWEEN DIET AND BREAST CANCER MUST ALSO BE FURTHER INVESTIGATED. SOME CULTURES EXPERIENCE FAR FEWER CASES OF BREAST CANCER THAN WE DO, AND DIET MAY BE THE KEY. A MAJOR TRIAL TO INVESTIGATE THIS RELATIONSHIP, AMONG THOSE WE WILL HEAR ABOUT TODAY, WAS DENIED FEDERAL FUNDING LAST YEAR IN SPITE OF HIGH RECOMMENDATIONS FROM PEER REVIEW. THERE IS CONSIDERABLE EVIDENCE THAT THE DAUGHTERS AND EVEN THE GRAND-DAUGHTERS OF MOTHERS EXPOSED TO THE DRUG DIETHYLSTILBESTROL (DES) SOME THIRTY YEARS AGO RUN A HIGHER THAN AVERAGE CHANCE OF GETTING BREAST CANCER. OF LATE, IT HAS BECOME ALL TOO COMMONPLACE FOR RESEARCH PROPOSALS AT NCI TO GENERATE EXCELLENT RECOMMENDATIONS AT BOTH PEER REVIEW AND ADVISORY LEVELS AND YET NOT RECEIVE FUNDING. THE MONEY JUST IS NOT THERE.

WITH THE EXPECTED DEATHS OF 43,000 AMERICAN WOMEN THIS YEAR, THE INCIDENCE OF BREAST CANCER HAS MOST CERTAINLY REACHED CRISIS PROPORTIONS SIMILAR TO OTHER DISEASES, SUCH AS AIDS. I APPLAUD THE EFFORT OF CONGRESS TO FULLY FUND THE AIDS RESEARCH PROGRAM WITH THE $1.6 BILLION SO URGENTLY NEEDED LAST YEAR. I AM EQUALLY PLEASED TO SEE THAT THE BUDGET COMMITTEE HAS EARMARKED AN ADDITIONAL $700 MILLION FOR AIDS RESEARCH THIS YEAR. RECENT STRIDES IN AIDS RESEARCH PROVE WHAT WE CAN ACCOMPLISH IN MEDICAL RESEARCH WHEN WE PROVIDE ADEQUATE FUNDING. SIMILARLY, AN ADDITIONAL $25 MILLION IN FUNDING FOR BREAST CANCER RESEARCH IS A SMALL PRICE TO PAY FOR A CHANCE TO ADVANCE A CURE. A BREAKTHROUGH IN BREAST CANCER ETIOLOGY COULD ALSO MEAN NEW INROADS TO THE UNDERSTANDING OF OTHER CANCERS.

MR. CHAIRMAN, BREAST CANCER IS NOT SOLELY A CONCERN FOR WOMEN. BREAST CANCER UPROOTS AND BANKRUPTS FAMILIES, ORPHANS CHILDREN, AND WIDOWS SPOUSES. ALL OF US KNOW OF SOMEONE WHOSE LIFE HAS BEEN DISRUPTED BY THIS KILLER. MANY OF OUR COLLEAGUES HAVE LOST LOVED ONES TO BREAST CANCER, AND A FEW HAVE BATTLED IT THEMSELVES. I HAVE A FAMILY HISTORY OF BREAST CANCER.

MR. CHAIRMAN, I THANK YOU FOR AGREEING TO WORK WITH ME TODAY TO BRING THESE ISSUES BEFORE THE AMERICAN PEOPLE. THE BOTTOM LINE IS THAT NINETY PERCENT OF ALL MEDICAL RESEARCH CONDUCTED IN THE UNITED STATES RECEIVES SOME FEDERAL SUPPORT. WITHOUT SUCH EFFORTS, IT IS DOUBTFUL THAT WE WOULD BE THE COMPETITIVE FORERUNNERS IN MEDICAL RESEARCH THAT WE ARE TODAY. IT IS TRUE FOR TOO MANY WOMEN IN THIS COUNTRY THAT THE "RACE FOR THE CURE" IS A RACE FOR THEIR LIVES. WITH THAT SAID, LET THE RACE BEGIN.

Chairman ROYBAL. The Chair now recognizes Mr. Regula.

## STATEMENT OF REPRESENTATIVE RALPH REGULA

Mr. REGULA. Thank you, Mr. Chairman.

I would ask unanimous consent to put my remarks in the record.

Chairman ROYBAL. Without objection.

[The prepared statement of Mr. Regula follows:]

## OPENING STATEMENT OF THE HONORABLE RALPH REGULA, VICE-CHAIRMAN

I THANK THE DISTINGUISHED GENTLEMAN FROM CALIFORNIA FOR HIS EFFORTS IN CALLING THIS HEARING ON THE STATUS OF BREAST CANCER IN AMERICA.

THIS YEAR OVER 71,000 ELDERLY WOMEN WILL BE STRICKEN WITH SOME FORM OF BREAST CANCER. IT IS MY HOPE AND DESIRE THAT RELIEF CAN COME TO THOSE SUFFERING UNDER THIS BURDEN. AS WILL BE HIGHLIGHTED BY THIS HEARING, PUBLIC POLICY MUST EMPHASIZE PREVENTION AND THEN TREATMENT WHICH RESULTS IN A CONCLUSIVE CURE.

APPROXIMATELY 45% OF NEW BREAST CANCERS ARE DETECTED AFTER THE AGE OF 65. THEORETICALLY, SCREENING ELDERLY WOMEN UNDER MEDICARE COULD DECREASE BREAST CANCER MORTALITY BY AS MUCH AS 30%. A RECENT OFFICE OF TECHNOLOGY ASSESSMENT

STUDY INDICATES SUCH A PROGRAM WOULD COST $185 MILLION ANNUALLY ABOVE THE SAVING FROM DECREASED TREATMENT. HOWEVER, THE SAVINGS IN HUMAN SUFFERING FAR OUTWEIGH THIS EXPENSE. WE HAVE THE MEANS, TODAY, TO REDUCE THESE DEATHS AND WE SHOULD DO IT.

I HAVE INTRODUCED LEGISLATION (HR4269) TO PROVIDE FOR A COMPREHENSIVE PACKAGE OF PREVENTIVE HEALTH CARE PROCEDURES THAT WILL BE REVIEWED BY MEDICARE AND MADE INTO PERMANENT LAW IF FOUND EFFECTIVE. OVER 50 MEMBERS OF OUR COMMITTEE HAVE SPONSORED THIS BILL. CONSPICUOUSLY, WE HAVE OMITTED MAMMOGRAPHY FROM OUR PROPOSAL. THE REASON IS TO GIVE MY FULL SUPPORT TO THE EFFORTS OF CONGRESSWOMAN OAKAR AND OUR COLLEAGUES ON THE WAYS AND MEANS COMMITTEE. HER LEGISLATION, HR 3864, TO PROVIDE ANNUAL MAMMOGRAMS IS LONG OVERDUE.

EDUCATIONAL MATERIALS DESCRIBING SELF-EXAMINATION AND INCREASED FUNDING FOR DIAGNOSTIC RESEARCH ARE SOME EXAMPLES OF

AN EFFECTIVE PREVENTION STRATEGY. ALSO, STRONG RISK FACTORS SUCH AS A FAMILY HISTORY OF BREAST CANCER AND MORE MINOR FACTORS SUCH AS OBESITY, HIGH-FAT DIET, AND FIRST PREGNANCY AFTER AGE 35 SHOULD FOCUS OUR SCREENING EFFORTS IN THE FUTURE. PREVENTION STILL REMAINS THE MOST EFFECTIVE WAY OF CURRENTLY DEALING WITH THIS PROBLEM.

FINALLY, ACTION MUST BE TAKEN TO ENCOURAGE THE NECESSARY RESEARCH TO FIND THE CURE TO THIS AFFLICTION. I SUPPORT THE PROPOSAL BY MY COLLEAGUE FROM OHIO, HR 3251, WHICH WOULD EARMARK AN ADDITIONAL $25 MILLION FOR THE NATIONAL CANCER INSTITUTE TO CONDUCT BASIC RESEARCH TOWARD A CURE FOR BREAST CANCER.

I APPRECIATE OUR DISTINGUISHED PANEL OF WITNESSES AND LOOK FORWARD TO THEIR INSIGHTS ON THIS MATTER.

Mr. **Regula**. Thank you, Marilyn, for coming to this hearing. You've done a wonderful thing by bringing visibility to this problem. You will never know probably how many lives you will save. Because of your interest, women will get screening at an earlier point in their lives; they will be more aware of it; and because of that lives will be saved.

I think the one place we have not done enough in the whole area of medicine is preventive medicine. And the run will be a good thing because at least it will perhaps get some people out moving that otherwise would not be.

But because of your interest in this problem, I am sure that reaches out all across the country and will cause women to get the screening. We have legislation in to make this a Medicare reimbursable program and, again, I think that would do a lot to establish a system of preventive medicine in this field.

But I salute you for what you have done thus far, and the whole Nation is indebted to you for your leadership.

Thank you.

Chairman **Roybal**. Thank you, Mr. Regula.

The Chair would like to welcome a brand new member of this committee; a man who got on this committee because of his interest in the problems of the aging in this country. That gentlemen is Mr. Wayne Owens, who sits to my right and to the right of Mary Rose Oakar.

Now he just sent me a little note containing a message which is unusual for a new member but very much welcome. In that note he says that, because of lack of time, he would like to submit his opening statement for the record.

Is there objection on the part of the members of the committee?

[No response.]

Chairman **Roybal**. The Chair hears none. His opening statement will be included at this point in the record.

[The prepared statement of Mr. Owens follows:]

## PREPARED STATEMENT OF REPRESENTATIVE WAYNE OWENS

I would first like to say, as a new member of the Select Committee on Aging and Sub-Committee on Health and Long Term Care, how delighted I am to have been appointed to such an important Committee. As the Baby Boomer generation makes long term plans for retirement and health care costs are becoming more and more a major topic for national debate, this is a critical time to be serving on this committee.

I commend Chairman Roybal and Congresswoman Oakar for holding this timely and important hearing on Breast Cancer. The women of the post World War II population explosion are now approaching the age where their bodily defenses against breast cancer are diminishing.

The statistics are a matter of great concern to me, both on the national level and in my state of Utah. Nationally, 1 of every 10 women will develop breast cancer at some time. In Utah, where it is the second most common cancer, approximately 1 in 13 women will develop breast cancer. In 1987, a survey taken by the Utah Department of Health, recorded that a significant proportion (up to 79%) of Utah women 40 and older had never had a mammogram. In 1990, an estimated 44,300 nationwide will die from breast cancer and about 135,000 women will be diagnosed with the disease. In Utah an estimated 550 women will develop breast cancer in 1990 and 150 will die. Nationally a woman is diagnosed with breast cancer every five minutes, and one breast cancer related death occurs every 15 minutes.

And yet, if detected early enough, breast cancer is nearly 100% curable. Studies have shown mammographic screening and physical breast examination by a health care professional can reduce the death rate from breast cancer from 30 - 50% in women 50 years and older. According to the American Cancer Society's National Task Force on Breast Cancer, mammography screening is the most valuable tool in the detection of breast cancer. Mammographies can detect breast cancer years before either a physician or self-examination can discover the problem. With today's medical advances, no woman need die from lack of knowledge or shyness. To avoid testing is to run an unnecessary risk.

Education is just as important as treatment. I am proud to recognize an organization in my congressional district which has taken on the fight against breast cancer mortality. A coalition of interested practitioners, individuals and representatives of cancer-related agencies and professional organizations has formed a Breast Cancer Task Force in Utah. This task force is determined to reduce unnecessary deaths from breast cancer through a coordinated and comprehensive statewide approach to early detection, diagnosis, treatment and follow-up. I commend their efforts wholeheartedly and pledge to join them in raising public awareness about this potentially terminal disease which is all the more tragic because it is curable.

I would also like to commend Congresswoman Oakar for introducing legislation which would earmark an additional $25 million for the National Cancer Institute to conduct basic research towards a cure for breast cancer. Congressman Stark has introduced the Medicare Benefits Improvement Act which restores benefits for biennial mammography screening for elderly and disabled medicare beneficiaries which were repealed along with the Medicare Catastrophic Act last year. This legislation could save the lives of 4,000 women annually.

I look forward to hearing the testimony of our distinguished witnesses.

Chairman **Roybal**. I thank you, Mr. Owens, and welcome you to the committee. I don't know if you've been assigned to various subcommittees yet, but when you do you will find that you will be working almost every day on some of these pressing problems.

The next witness is a man that serves with me on the Committee on Appropriations, one of the leaders in that particular committee, but also a gentleman who has great interest in the problems of the aging. The Chair now recognizes Mr. Myers.

### STATEMENT OF REPRESENTATIVE JOHN T. MYERS

Mr. **Myers**. Thank you, Mr. Chairman, and good morning, Marilyn. I'm pleased to see you here and thank you, Mr. Chairman, for allowing me to sit in today. I'm not a member of this committee but I have a new interest in finding a cure, as well as a prevention, too, for cancer.

Cancer usually hits someone else. It's usually in someone else's family where cancer strikes. I have prayed through the years for other people, but I never had to pray for anybody in my family. Last night, the mother of a staff member of mine died of breast cancer back in Indiana.

And I might say this Marilyn, back in Indiana people don't like to talk about the big "C," and I think this is wrong. Cancer is not something that we can run away from—I wish we could. But it is something that we should and ought to admit. I think the sooner people face up to this and talk about it, the quicker we will find answers for cancer.

I am pleased to see you here taking an active role in finding a cure for cancer. I join you and I certainly will be taking an interest. Mr. Chairman, you and I came to Congress together a good many years ago, and I have a renewed interest in helping solve this problem. I can assure you for several of us on this committee who serve on the Appropriations Committee, we will be working to increase the amount of money this year in research for cancer.

I asked a question the other day in a Subcommittee meeting on Appropriations as to why we were continuing to spend more money on AIDS research than we do on either heart or cancer research, when we lose more lives each year to heart disease and cancer than we do from AIDS. Now I'm not suggesting we shouldn't spend research dollars on AIDS. But it seems to me it's out of proportion when there is $1.7 billion budget for AIDS and only $1.6 billion for cancer, and $1.5 billion for heart. I think we need to look at the priorities here and that's something we on the Appropriations Committee will have to do.

We do appreciate your concern. And I share the chairman's wish that, hopefully, many thousands of lives will be saved because people like you will take an interest in doing something about finding a cure for cancer. From a personal standpoint, you have a vested interest, too and we appreciate that.

Thank you for coming here today.

Chairman **Roybal**. Thank you, Mr. Myers.

This committee always welcomes the participation of the members of the Appropriations Committee. The reason for that is quite obvious: whatever is recommended or whatever is done by any other committee is finally determined by what the Committee on Appropriations does. If there's no money for it and if no money is appropriated for it, then nothing happens. So the more members of the Appropriations Committee who come before this committee and make a commitment to being helpful, the better it is for our cause. So I welcome the gentleman, and he can be assured that he will be most helpful when the time comes.

The Chair now recognizes Mr. Skelton.

## STATEMENT OF REPRESENTATIVE IKE SKELTON

**Mr. SKELTON.** Mr. Chairman, I congratulate you and our colleague from Ohio, Mary Rose Oakar, for calling this hearing. I will not take but a moment, but, Mr. Chairman, I point out the fact that I lost my mother as a result of this very same issue which will be discussed I have a keen interest in.

**Chairman ROYBAL.** Thank you.

Mr. Downey.

## STATEMENT OF REPRESENTATIVE THOMAS J. DOWNEY

**Mr. DOWNEY.** Mr. Chairman, I also congratulate you and Ms. Oakar for having this hearing. And I thank Mrs. Quayle for coming and for her participation and the witnesses that follow, who will make a very big difference in the understanding of this issue. It is true that an ounce of prevention is worth a pound of cure, and this hearing should make more people aware of this.

I would ask unanimous consent that my opening statement be included in the record.

**Chairman ROYBAL.** Without objection, that will be the order.

[The prepared statement of Mr. Downey follows:]

### STATEMENT OF THE HON. THOMAS J. DOWNEY (D-NY)
### "BREAST CANCER: THE RACE FOR THE CURE"
MAY 16, 1990

I COMMEND MY COLLEAGUES, CHAIRMAN ROYBAL AND MS. OAKAR, FOR CALLING THIS HEARING TODAY. AS THE CHAIRMAN OF THE SELECT COMMITTEE ON AGING'S SUBCOMMITTEE ON HUMAN SERVICES, I WOULD LIKE TO ADD MY SUPPORT TO THE WORK BEING DONE BY THIS COMMITTEE TO FOCUS NATIONAL ATTENTION ON THE PROBLEM OF BREAST CANCER. THE DISTINGUISHED LATE CHAIRMAN OF THE COMMITTEE, CLAUDE PEPPER, A LONG-TIME SUPPORTER AND PIONEER IN THE EFFORTS TO PREVENT AND TREAT CANCER, WOULD HAVE BEEN VERY PROUD OF THE EFFORTS BEING MADE HERE TODAY.

ESTIMATES INDICATE THAT 10% OF AMERICAN WOMEN WILL DEVELOP BREAST CANCER DURING THEIR LIFETIMES. IN 1990, IT IS EXPECTED TO STRIKE NEARLY 150,000 WOMEN IN THIS COUNTRY, AND CLOSE TO 44,000 WILL DIE. IN MY HOME STATE OF NEW YORK, OUT OF 39,000 EXPECTED TO DIE FROM ALL TYPES OF CANCER THIS YEAR, 3,800 WILL DIE FROM BREAST CANCER ALONE. BREAST CANCER IS MOST COMMON IN WOMEN OVER THE AGE OF 50, AND THE INCIDENCE INCREASES WITH AGE.

BREAST CANCER IS A DEVASTATING DISEASE THAT KNOWS NO REAL SOCIAL BOUNDARIES, BUT WHICH, WITH EARLY DETECTION, CAN BE TREATED. IT IS A DISEASE THAT NOT ONLY CAN BE FATAL, BUT THAT CAN ALSO WREAK PHYSICAL AND EMOTIONAL DAMAGE, IF NOT DETECTED IN TIME. IT AFFECTS NOT ONLY THE VICTIM, BUT THE FAMILY OF THE VICTIM AS WELL.

THE LONG NATURAL HISTORY OF BREAST CANCER MAKES THE DISEASE AN IDEAL MODEL FOR EARLY DETECTION AND INTERVENTION. THERE HAVE BEEN DEVELOPMENTS IN THE PREVENTION AND TREATMENT OF BREAST CANCER IN RECENT YEARS. BUT MUCH MORE NEEDS TO BE DONE IF WE ARE TO ELIMINATE THE DISEASE ALTOGETHER. WHETHER IT BE

A DIETARY ISSUE, A GEOGRAPHICAL ISSUE OR A GENETIC ISSUE, THE PROBLEM WILL CONTINUE TO SPREAD UNTIL THERE IS A CURE. MORE FUNDING IS NEEDED FOR CONTINUED RESEARCH, AND THE FEDERAL GOVERNMENT MUST CONTINUE TO SHOW ITS COMPASSION AND CONCERN FOR THE GROWING NUMBER OF WOMEN WHO ARE AFFLICTED EACH YEAR BY EARMARKING SPECIFIC FUNDS FOR THIS PURPOSE.

BECAUSE EARLY DETECTION IS THE KEY TO DECREASING THE NUMBER OF DEATHS, A HEIGHTENED AWARENESS OF BREAST CANCER IS OF VITAL IMPORTANCE TO ALL PHYSICIANS AND THEIR PATIENTS. THE AMERICAN CANCER SOCIETY RECOMMENDATIONS REGARDING BREAST SELF EXAMINATION, PHYSICIAN EXAMINATION AND MAMMOGRAPHY ARE IMPORTANT, BUT OFTEN OVERLOOKED, TECHNIQUES. THE PUBLIC MUST BE BETTER EDUCATED, SO THAT THE NUMBERS OF DEATHS FROM BREAST CANCER WILL BEGIN TO DIMINSH.

THE SUBCOMMITTEE ON HUMAN SERVICES IS PARTICULARLY INTERESTED IN PROMOTING THE HEALTH EDUCATION AND PROMOTION SECTION OF THE OLDER AMERICANS ACT, TITLE III (F). THE FUNDS FOR THIS IMPORTANT PROGRAM HAVE NOT BEEN APPROPRIATED SINCE IT WAS FIRST AUTHORIZED IN 1987. I WILL BE HOLDING A SUBCOMMITTEE HEARING, WITH MY COLLEAGUE CONGRESSWOMAN SLAUGHTER, IN ROCHESTER, NEW YORK ON JUNE 11 WHICH WILL FOCUS ON TITLE III (F) AS WELL AS THE OTHER UNFUNDED PROGRAMS IN THE OLDER AMERICANS ACT. IT SEEMS TO ME THAT EARLY DETECTION PROGRAMS FOR BREAST CANCER WOULD BE A NATURAL COMPONENT OF THESE HEALTH EDUCATION AND PROMOTION ACTIVITIES.

THE "RACE FOR THE CURE" SCHEDULED FOR JUNE 16 IS YET ANOTHER WAY WE CAN SHOW OUR COMMITMENT TO FINDING A CURE FOR BREAST CANCER. THE APPROXIMATELY 4000 PEOPLE WHO ARE SCHEDULED TO PARTICIPATE, MANY CANCER VICTIMS AMONG THEM, ARE TAKING THE FIRST STEP TOWARD REACHING THE REST OF THE NATION. IT IS OUR DUTY TO JOIN IN THE RACE.

Chairman **Roybal**. The Chair recognizes Mr. Bilbray.

## STATEMENT OF REPRESENTATIVE JAMES H. BILBRAY

Mr. **Bilbray**. Mr. Chairman, I also want to thank you for having this hearing along with my colleague Mary Rose Oakar; Mrs. Quayle; and my colleague from Nevada, who is a big pusher in this particular problem because of her own problems and plus the caring that she feels for people that suffer, Mrs. Vucanovich of Nevada.

I truly support this legislation and hope that Ms. Oakar can get this pushed through, along with my colleague Mrs. Vucanovich, and we can get this money into these programs that are so needed. It's something that we have to look at; and I think we can do with maybe one less B-2 bomber next year and put the money into something that's needed as this type of research.

Thank you.

Chairman **Roybal**. Thank you.

Mr. Hertel.

## STATEMENT OF REPRESENTATIVE DENNIS M. HERTEL

Mr. **Hertel**. You know, so often we work very hard on pieces of legislation and we wonder even if it gets passed if it will make a difference; if it will work; if it will be applied properly. That's why I really commend you, Mr. Chairman, for holding this hearing, and Ms. Oakar, on this legislation because here we can see that we could make a difference—or detection would make a difference, and it would save lives; it would be so very clear and so very decisive. So I hope we can move ahead on this. I know that the priorities of the American people would be for doing more in this entire area; so I hope that we can get the appropriations for it, as you mentioned.

Chairman **Roybal**. Thank you.

At this time, I would like to introduce for the record the prepared statements of Representatives Norman Sisisky and Richard T. Schulze. Hearing no objections, so ordered.

[The prepared statements of Representatives Sisisky and Schulze follow:]

NORMAN SISISKY
4TH DISTRICT, VIRGINIA

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PROCUREMENT AND MILITARY NUCLEAR SYSTEMS SUBCOMMITTEE
SEAPOWER AND STRATEGIC AND CRITICAL MATERIALS SUBCOMMITTEE
INVESTIGATIONS SUBCOMMITTEE
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## HEARING BY THE SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE OF THE HOUSE SELECT COMMITTEE ON AGING

## "BREAST CANCER: RACE FOR THE CURE"
## MAY 16, 1990

## STATEMENT BY CONGRESSMAN NORMAN SISISKY (VA-4)

MR. CHAIRMAN, REPRESENTATIVE OAKAR, I WANT TO THANK YOU FOR CALLING THIS HEARING TODAY TO FOCUS ON A DISEASE THAT HAS DESTROYED THE LIVES OF SO MANY WOMEN AND THEIR LOVED ONES--BREAST CANCER.

THIS IS CERTAINLY AN IMPORTANT AND TIMELY ISSUE FOR THIS SUBCOMMITTEE TO CONSIDER. THE DEVELOPMENT OF BREAST CANCER AMONG WOMEN IS OCCURRING AT AN INCREASING RATE, ESPECIALLY AMONG WOMEN BEYOND THEIR CHILD BEARING YEARS. IN FACT, WOMEN OVER THE AGE OF 65 HAVE EXPERIENCED THE HIGHEST PERCENTAGE INCREASE IN BREAST CANCER INCIDENCE OF ANY AGE GROUP. THIS IS PARTICULARLY DISTURBING SINCE THESE WOMEN ARE MOST VULNERABLE TO THE EXORBITANT COSTS OF BREAST CANCER TREATMENT.

I WANT TO THANK THE DISTINGUISHED PANEL OF WITNESSES FOR TESTIFYING BEFORE US TODAY AND FOR THEIR EFFORTS OUTSIDE OF THIS COMMITTEE ROOM TO FIGHT THIS DISEASE. I TOO AM HONORED TO HAVE AMONG OUR WITNESSES THE WIFE OF THE VICE-PRESIDENT OF THE UNITED STATES, MRS. MARILYN QUAYLE, WHO HAS SUFFERED THE TRAGIC LOSS OF HER MOTHER TO BREAST CANCER. ADDITIONALLY, WE ARE MOST FORTUNATE TO HAVE MRS. QYAYLE AND LYNDA CARTER CHAIR THE FIVE KILOMETER "RACE FOR THE CURE" ON JUNE 16, 1990 WHICH WILL HOPEFULLY BRING MORE NATIONAL ATTENTION TO THIS DISEASE.

THE BENEFITS OF EARLY DETECTION HAVE BEEN FULLY CLARIFIED DURING PREVIOUS HEARINGS HELD BY THIS SUBCOMMITTEE. RESEARCH INTO THIS DISEASE IS BECOMING MORE AND MORE PROMISING. THUS, A VITAL PART OF THE SOLUTION IS TO INCREASE PUBLIC AWARENESS OF BREAST CANCER, SO THAT MORE WOMEN WILL SEEK THE SCREENING THEY NEED, AND, MOST IMPORTANTLY, THERE WILL BE MORE PUBLIC SUPPORT FOR FINDING A CURE. EFFORTS SUCH AS THIS HEARING TODAY AND THE "RACE FOR THE CURE" ON JUNE 16 WILL HELP SAVE THE LIVES OF MANY WOMEN IN THE FUTURE.

THANK YOU.

TESTIMONY BY THE HONORABLE RICHARD T. SCHULZE
SELECT COMMITTEE ON AGING
STATEMENT FOR THE RECORD
May 23, 1990

I THANK THE GENTLEMAN FROM CALIFORNIA AND GENTLE LADY FROM OHIO FOR HOLDING THIS HEARING ON BREAST CANCER AND ALLOWING ME THE OPPORTUNITY TO SUBMIT TESTIMONY FOR THE RECORD.

IT IS PARTICULARLY DIFFICULT, BUT VERY NECESSARY, THAT I JOIN YOU IN DISCUSSING BREAST CANCER. LESS THAN 90 DAYS AGO, MY WIFE NANCY DIED FROM THIS DREADED DISEASE.

NANCY WAS ONE OF 43,000 WOMEN WHO ARE ESTIMATED TO DIE THIS YEAR FROM BREAST CANCER. BREAST CANCER IS TAKING LIVES AROUND THE WORLD AT AN ALARMING RATE. TODAY, ONE IN TEN WOMEN IN AMERICA WILL BE DIAGNOSED WITH BREAST CANCER. THE AMERICAN CANCER SOCIETY ESTIMATES THAT 143,000 WOMEN IN THE U.S. WILL DEVELOP BREAST CANCER THIS YEAR ALONE. THIS IS A HOLOCAUST AGAINST THE WOMEN OF AMERICA AND IT MUST BE STOPPED.

HAVING BEEN BY NANCY'S SIDE DURING HER LAST MONTHS OF LIFE, AS SHE FOUGHT THE CANCER, I CAN ONLY TELL YOU HOW HORRIBLE THIS DISEASE IS. MY WIFE WAS AN OUTGOING AND BEAUTIFUL WOMAN, AND SHE DEDICATED HER LIFE TO OUR FAMILY, FRIENDS AND COUNTRY. WITH THE BILLIONS WE SPEND ON MEDICAL RESEARCH, WE COULDN'T SAVE HER. IT MAY TAKE BILLIONS MORE BEFORE WE FIND A CURE, BUT WE WILL. I URGE AMERICANS TO REALIZE THAT EACH INDIVIDUAL IN OUR NATION IS PART OF THE WAR ON BREAST CANCER. IN OUR LIFETIMES, WE WILL ALL BE AFFECTED. FORTUNATELY, THERE ARE MANY WAYS TO HELP FIGHT THIS BATTLE.

FIRST, WE MUST ENCOURAGE WOMEN, ESPECIALLY THOSE OVER 35, TO HAVE MAMMOGRAPHY EXAMINATIONS FOLLOWED BY SELF-EXAMINATIONS. THE BEST TREATMENT TO REDUCE BREAST CANCER IS EARLY DETECTION. I HAVE CO-INTRODUCED LEGISLATION, H.R. 4109, TO PROVIDE MEDICARE COVERAGE FOR MAMMOGRAPHY SCREENING FOR WOMEN OVER 35, WHO ARE MEDICARE-ELIGIBLE. CURRENTLY, MEDICARE COVERS ONLY DIAGNOSTIC MAMMOGRAPHY BECAUSE IT GENERALLY PAYS ONLY FOR TREATMENT, NOT

PREVENTATIVE SERVICES. MAMMOGRAPHY SCREENING CAN DETECT CANCERS THAT ARE TOO SMALL TO BE FELT THROUGH PHYSICAL EXAMINATION. CANCERS DETECTED IN THESE EARLY STAGES CAN BE 90 TO 100 PERCENT CURABLE.

WOMEN SIMPLY NEED TO BECOME BETTER EDUCATED ON THE IMPORTANCE AND VALUE OF MAMMOGRAPHY SCREENING. STUDIES INDICATE THAT APPROXIMATELY 60 PERCENT OF WOMEN 40 AND OVER HAVE NEVER HAD A SCREENING MAMMOGRAM.

SECOND, WE CAN ALL CHIP IN TO RAISE THE MONEY NECESSARY TO FIND A CURE FOR CANCER. NEW AND EXPERIMENTAL TREATMENTS LIKE AUTOLOGOUS BONE MARROW TRANSPLANT, (ABMT), ARE VERY COSTLY AND OFTEN NOT COVERED BY INSURANCE PLANS. WHETHER WE WALK OR RUN IN CHARITY EVENTS, SUCH AS THE WASHINGTON RACE FOR THE CURE ON JUNE 16TH, OR SIMPLY CONTRIBUTE TO THE CANCER RESEARCH FUND OF OUR CHOICE, WE HELP IN THE FIGHT TO BEAT BREAST CANCER.

THIRD, WE CAN WATCH OUR DIETS AND INTAKE OF CANCER CAUSING SUBSTANCES, INCLUDING TOBACCO. AMERICANS CAN ENCOURAGE FAMILY

MEMBERS TO QUIT SMOKING. WE CAN MAKE A DIFFERENCE, ESPECIALLY WITH FAMILY MEMBERS, IN ENCOURAGING HEALTHY LIFESTYLES.

FINALLY, ALTHOUGH THERE ARE MANY MORE THINGS WE CAN DO TO FIGHT BREAST CANCER, WE CAN SPREAD THE WORD ABOUT THIS DREADED DISEASE TO OUR FRIENDS AND NEIGHBORS. ITS NOT A PLEASANT SUBJECT, BUT IT MAY SAVE LIVES DISCUSSING IT.

SINCE NANCY DIED ON FEBRUARY 16TH, THE RESPONSE FROM OUR FRIENDS AND FAMILIES HAS TOUCHED MY HEART. THOUSANDS OF LETTERS AND CARDS HAVE POURED IN AND THE NANCY SCHULZE MEMORIAL CANCER FUND HAS RECEIVED OVER $20,000 IN CONTRIBUTIONS. I WANT TO THANK ALL OF THOSE WHO EXPRESSED THEIR LOVE FOR NANCY.

NANCY'S LIFE WAS DEDICATED TO HELPING OTHERS. I HOPE AND PRAY THAT SOMEONE, ANY ONE OF US, WILL DEDICATE ENOUGH ENERGY TO FIND A CURE FOR CANCER. A CURE SO THAT 43,000 WOMEN IN EACH FUTURE YEAR WILL BE SAVED, AND THOUSANDS OF SONS, DAUGHTERS AND HUSBANDS WITH THEM, SPARED.

Chairman Roybal. Our first witness today is the spokesperson of the Race for the Cure. And this, ladies and gentlemen, is a 5-mile walk or run to take place on June the 16th. Its aim is to raise funds for breast cancer. She is, of course, a worthy spokesperson. She is a woman at risk. She is the daughter of a mother who died of breast cancer, and the wife of the Vice President of the United States.

I am very much interested in the 5-mile walk instead of the 5-mile run. I used to jog at one time, but now I go in for the walking part of it. I would like to be present, if at all possible, to take part in that 5-mile walk.

The Chair is now happy to recognize the wife of the Vice President of the United States, Mrs. Marilyn Quayle.

## STATEMENT OF MARILYN QUAYLE, WIFE OF THE VICE PRESIDENT OF THE UNITED STATES AND HONORARY CO-CHAIRMAN, 5K RACE FOR THE CURE

Mrs. Quayle. Mr. Chairman and members of the subcommittee:

Thank you for your interest on the very timely and important topic of breast cancer. As the chairman said, on Saturday, June 16, an exciting event will be occurring in Washington, DC: the Komen Foundation's Race for the Cure of Breast Cancer will be held.

This will symbolically start a national effort to end breast cancer. This event will be a 5K run, a 5K walk, and a 1-mile fun walk, to benefit breast cancer research, detection, and education.

Eight years ago, the first Race for the Cure of Breast Cancer was held in Dallas, Texas. Since that time, the interest in the Race for the Cure and in cancer awareness in general has grown. In fact, there will be 8 races held in communities across this country this year alone. These races not only raise money for breast cancer research but they give the community an opportunity to focus on early detection and on general breast cancer awareness.

The Washington, DC race is unique, in that it is focusing on the importance of families and of individuals of any age, and of both sexes, to be aware of the importance of early detection of breast cancer, and also to emphasize the need for all people to address the growing concern that 1 in 9 women will have breast cancer in the United States.

The Washington, DC race is emphasizing that breast cancer is a family issue. Husbands who care about their wives, children who care about their mothers, and brothers who care about their sisters, should insist that their loved ones have a mammogram, and should encourage monthly breast self-examination. They should also encourage research for prevention or a cure of breast cancer.

Let's face it, more than one life is touched when breast cancer rears its ugly head. Women play an integral part in all aspects of human life. The void left by a mother felled by late detected breast cancer can never be filled. The lives of her husband and her children will never be the same.

The lives of her coworkers will also feel the void left by her passing.

When, in 1987, over 1 million women have or have had breast cancer, and there are 150,000 new cases each year, with over 40,000 women dying of the disease, it is time for the whole population to stand up and to do all that they can to ensure our populous is educated as to what helps detect breast cancer in its earliest stages.

I don't have to tell Members of this body how breast cancer touches their lives. We each know of the courageous war Congresswoman Vucanovich has waged against this disease. We are all aware of the number of Members whose wives are battling breast cancer; and we have wept for those Members whose wives have lost their battle.

Not one of us has been untouched. Our families and our lives have been forever changed because breast cancer has entered them.

It is, in my opinion, important for Members of Congress to lead the way to set an example. That's why I would encourage all Members of Congress, their spouses, and children, to participate in the Race for the Cure of breast cancer. Maybe, by emphasizing your concern, one person will get a mammogram who might not have done so.

Maybe that person's cancer will be detected early enough that the survival rate will be 92 percent.

Maybe one child will be so inspired by you and your family's involvement that that child will encourage his mother to get a mammogram.

Maybe the money raised from this event will help to find a cure for breast cancer.

By standing up and being counted, by running, walking, or just standing on the sidelines cheering the racers on, on June 16 you will be making a statement that we are losing too many good women to breast cancer each year; that we will no longer tolerate the emptiness in our families when our mother, sister, or wife is lost to breast cancer.

Heightened awareness, low-cost screening for the low-income members of our community, and money for research is what the Komen Foundation's Washington Race for the Cure is all about.

I look forward to having all of you and your families join the Vice President, Tucker, Benjamin, Corinne and me on June 16 as we, together, race for the cure, a run for our lives, to end breast cancer.

Chairman ROYBAL. Thank you, Mrs. Quayle.

We are going to start with a series of questions. Each Member of the committee will be recognized for 5 minutes, and we will try to get to all of them. After that, if there is time available—and I hope there is—there will be another round of questions.

Now the first question that I would like to ask is as follows: Now, besides congressional hearings like this one, and the major events like the one that will take place on June the 16th—that is the Race for the Cure—what other activities would you recommend that we undertake together to raise public awareness on breast cancer ?

Mrs. QUAYLE. Given the high profile positions that each Member is in, I would encourage every Member to do what I do, which is, whenever I give a speech—whether it's to a chamber of commerce, to a women's group, to a business council—I bring up breast cancer, and the importance of screening. And I also bring up the importance—whether it's to a labor group or whatever—of trying to include a mammogram as part negotiations in insurance contracts for businesses.

It's far cheaper to have a mammogram as part of your health package than it is to have to pay for the long-term treatment of late term breast cancer. So be aware—go out and talk. Visit breast cancer screening centers in your communities. Bring public awareness forward within those communities. It's the only way we're going to heighten awareness and make people bring breast cancer out of the closet and talk about it so that people won't be afraid. The more we talk, the more we will banish the fear of breast cancer.

Chairman ROYBAL. Thank you, Mrs. Quayle. If at all possible, Mrs. Quayle, I would like to suspend questions and to recognize the other witnesses. I understand that you have an appointment elsewhere, and so do others. We'd like to keep you here for the rest of the day but that's not possible. So we will accede to that request—we will suspend the questions.

I would like to submit to you a list of two questions, at least, that you might answer for the record.

I am interested in what you are doing. I, as an individual, and a member of this committee, would like to be helpful, and I'm sure that the other members would, too. I am going to start by participating in the walk—not the run, but in the walk.

Mrs. QUAYLE. We welcome you.

Chairman ROYBAL. The question is, will I go 1 mile or 5 miles? If I have a companion member of this committee that wants to walk for 5, I will join him or her in that effort.

Mr. BILBRAY. I'll go with you.

Chairman ROYBAL. All right. Now I have a companion and we will both walk the 5 miles on June 16. And we welcome the participation of any other member of the committee.

The Chair will now recognize Mrs. Barbara Vucanovich.

## HON. BARBARA F. VUCANOVICH, A REPRESENTATIVE FROM THE STATE OF NEVADA

Mrs. VUCANOVICH. Good morning, and thank you, Mr. Chairman and members of the committee.

I appreciate the opportunity to testify today on a subject that's very important to me. In fact, I've made the fight against death from breast cancer my legislative priority. As Mary Rose Oakar knows since we've been working together on these efforts, my primary goal has been to work at the Federal level to make screening mammography available and affordable to women around the country.

My interest in helping to drive down the tragic number of deaths from breast cancer stems from my own personal experience. In February 1983, I followed the recommendation of the Office of the Capitol Physician and went for my first screening mammogram. Although I had always been very conscientious about regular physical checkups, and although I was 61 years old, no one had ever mentioned anything about mammograms to me before.

Unfortunately, that first mammogram detected a tumor, and prompt surgery saved my life. Early detection of my breast cancer allowed me to continue living an active and satisfying life, and caused me to dedicate myself to reducing breast cancer mortality.

I believe that Medicaid and Medicare are two of our most effective weapons to help women have access to early detection. Until there is a cure, early detection is the only means to turn breast cancer from a death sentence into a disease that can be survived in 90 percent of the cases.

As you know, Madam Chairwoman, together we introduced H.R. 3285, to mandate State coverage for screening mammography within Medicaid. In November, following the repeal of the Catastrophe Care Act, Congresswoman Cardiss Collins and I introduced H.R. 3701, to reinstate mammography screening in Medicare, and to reimburse for annual screening mammograms for women over the age of 65.

In 1989, more than 43,000 American women died from breast cancer, and it is expected that more than 44,000 women will die this year, from a disease that is usually survivable if detected early enough. Recent statistics on this chronic, epidemic disease show that 1 woman in 9 must now face the prospect of breast cancer in her lifetime; almost 3 times the number of incidences only 20 years ago.

We've declared war on breast cancer, and this time it is not a fight to the death, but a fight until there are no more deaths—and a race for the cure.

We have lost too many fine and courageous women, women like Rose Kushner and Nina Hyde, who have used their years of battling breast cancer as a crusade to save other women's lives. We cannot afford to lose more loved ones, and more women of this caliber.

As I see it, the war must be waged on two major fronts: making sure that every woman who needs one has access to affordable mammograms; and assisting those on the forefront of science who are searching for clues to the causes of breast cancer and its cure.

I recently met with Dr. Antonia Novello, our new U.S. Surgeon General, to ask her to join in this war. She is interested in our efforts, and in reaching out to minority women to educate them about the need for early detection. Dr. Novello is the first woman Surgeon General, and she has the added ability to reach out to Hispanic women, who are culturally reluctant to expose themselves to routine breast exams. I am optimistic that she will become an important ally in this war.

I don't believe that Congress should be in the business of micromanaging the National Cancer Institute, telling them which research grants to fund or making decisions about which research projects are most important. There is too close a relationship between cancers for Members of Congress to definitively rule on which projects are more likely to produce the cure for breast cancer.

Congress can be most effective, however, in providing sufficient funds to allow the National Cancer Institute to fund grants which have been approved by peer review and the National Cancer Advisory Board, and in providing sufficient funds to maintain studies which require longevity to produce accurate results.

Most of all, Members of Congress can be very effective, along with private sector initiatives like the Susan Komen Foundation, in raising awareness that we will make this war against breast cancer deaths a priority; and that we are not going to be distracted until the war is won.

As those of us in the House of Representatives have learned, the squeaky wheel does get faster response, and we must become vocal and insistent that breast cancer is a disease which must be overcome.

The Race for the Cure on June 16 will focus attention on our war, and many of us in this room will be participating in the event. The first Women's Leadership Summit on Mammography, held last September on Capitol Hill, is still showing results in women's publications and the media.

A second summit, focusing on treatment, is already in the planning stages for later in the year. We cannot lose this momentum, and there's too much at stake for us to fail. We cannot allow the number of breast cancer deaths to steadily increase. Until there's a cure, we can reduce the number of breast cancer deaths at least by half, starting this year, if every woman who needed a mammogram would routinely get one.

So, in the short term, my number 1 priority will be to do what I can to raise awareness of the need for mammograms, and to make mammograms available and affordable to women of all incomes.

In the long term, those of us in Congress and the private sector, who are committed to this issue, must work together to assist doctors and researchers in pointing out the cause of breast cancer and identifying the cure. This is a commitment that goes across party lines and endures from one session of Congress to the next.

This is a commitment which goes beyond the Federal Government to the individuals, businesses, foundations and organizations which focus on breast cancer, prevention, treatment, and the need for a cure. Together, and only together, this is a war that we can win.

Thank you, Madam Chairman, for giving me this opportunity to testify, and I hope that all the Members of Congress who are sitting upon the podium join us in the Race for the Cure.

Ms. OAKAR. [presiding] Thank you, Congresswoman. And thank you for your leadership on this issue and for talking about your personal experience. It's interesting to me how many of us have members of our families who have had breast cancer are affected by this terrible disease, and we need to have more people like yourself come out and speak about it.

I wanted to say to Marilyn Quayle, I know you and Barbara have to go for a meeting at the White House in the next few minutes, how grateful I am. We've had many marches on Washington, and sometimes they produce results. I'm hoping that because of your leadership, and Nancy Brinker, our next panel—Lynda Carter, Debbie Dingell, and others who are supportive of having women unite, and family members unite, to lick this disease once and for all, and to heighten awareness for it that we will have hundreds of thousands of people come to Capitol Hill to walk or run from the White House to the Capitol, and vice versa. I think that's very, very important.

So we want to thank you for being the honorary chair of that event. You had a meeting at your own residence with hosts of women throughout the country on this issue, and I remember attending. It's a nonpartisan issue as far as many of us are concerned. This is it. We want to see some things happen.

I'm going to ask my colleagues, unless they have a special question they want to ask Barbara, to suspend since she has to be at the White House, and we can get on with our next panel, if that's all right with my colleagues. It's the First Lady's luncheon—and I might add that Barbara Bush was very helpful in addressing the women who were present at the mammography seminar that we had some months ago. So we were very, very grateful.

Mr. **Myers**. Madam Chairman, would you yield?

Ms. **Oakar**. I'd be happy to yield.

Mr. **Myers**. Of course, Mrs. Regula is president of the Congressional Club.

Ms. **Oakar**. That's right.

Mr. **Myers**. She's going to head up the luncheon this year, and I hear Ralph's going to—

Ms. **Oakar**. That's right. Mary Regula has the greatest influence on her husband of anyone I know.

Mrs. **Vucanovich**. We'll ask her help.

Ms. **Oakar**. She's one of my favorite people as he knows.

Mr. **Bilbray**. Would the chairman yield for one second?

Ms. **Oakar**. I'd be happy to yield.

Mr. **Bilbray**. I'd just like to make a comment to my colleague, that I'm proud to serve with her and proud that she has pushed this bill. You can count on my support, and hopefully our two Senators from the other side.

Mrs. **Vucanovich**. Thank you very much, I appreciate it.

Ms. **Oakar**. Thank you very much, Barbara.

Mrs. **Vucanovich**. Thank you, Madam Chairman.

Ms. **Oakar**. Our next panel are really distinguished women, and if they would please come forward.

Nancy Brinker is the chair and founder of the Susan Komen Foundation of Dallas, Texas, and a member of the National Cancer Advisory Board.

Lynda Carter is the original, and will always be my personal Wonder Woman, a very marvelous actress, and co-chair of the Race for the Cure.

Debbie Dingell is well-known to all of us. She is the Director of the National Women's Health Resource Center, Columbia Hospital for Women. And, of course, she also wears a couple of hats—she is the wife of the Chairman of the House Committee on Energy and Commerce. In her own right, though, she has done fabulous things for all of us.

Isabel Hammond is the Executive Director of an organization called the American-Italian Foundation for Cancer Research of New York City.

I was recently made aware of this organization when they generously gave their private funding to two areas very near and dear to my heart—the Cleveland Clinic, for their wonderful research; and also a very important institute in Colombia, who are trying to do something about this dreaded disease as well.

We are delighted to have all of you here, and we'd like to begin with Nancy Brinker. Nancy, please proceed in whatever way is most comfortable for you.

## STATEMENTS OF NANCY G. BRINKER, FOUNDING CHAIRMAN, THE KOMEN FOUNDATION FOR THE ADVANCEMENT OF BREAST CANCER RESEARCH, EDUCATION AND TRAINING; LYNDA CARTER, ACTRESS, AND CO-CHAIR, 5K RACE FOR THE CURE; DEBORAH I. DINGELL, CHAIR OF THE BOARD OF DIRECTORS, NATIONAL WOMEN'S HEALTH RESOURCE CENTER, AND ISABEL HAMMOND, EXECUTIVE DIRECTOR, AMERICAN-ITALIAN FOUNDATION FOR CANCER RESEARCH, NEW YORK, NY

### STATEMENT OF NANCY G. BRINKER

Ms. **Brinker**. Madam Chairman and members of the committee, good morning. I am Nancy Brinker, the founder of the Susan Komen Foundation. I appreciate the opportunity to testify on behalf of this bill.

It is also very pleasing to follow my friends and colleagues, Marilyn Quayle and Barbara Vucanovich. Let me offer my thanks to Marilyn and the Vice President for chairing the Washington Race for the Cure, which is an effort of the Komen Foundation.

My sister, Susan Komen, died in 1980 of breast cancer. She was only 36. In 1984, I developed breast cancer. Her death and my disease inspired me to mobilize the private sector to support research on breast cancer.

According to the Centers for Disease Control in Atlanta, the death rate for breast cancer in the United States is increasing. In 1986, the most recent year for which complete statistics are available, for every 100,000 women, the statistic went up. 44,000 deaths are expected in 1990. In those same 7 years, the number of new cases rose by 24 percent. There's no known reason for this dramatic increase.

The gravity of this disease makes your support of increased funding for basic science essential. The cure, or at least the control of breast cancer, is going to come from the laboratory.

Over the past 8 years, the Komen Foundation, with the help of thousands of men and women across the country, has managed to raise several million dollars for research projects. But believe me, it is a drop in the bucket. We fund fellowships to try to inspire the best bright minds to get involved in this kind of research. But again, I must say to you, it is only a small private effort—nothing compared to what we can really do with government support; and real government support.

In the course of my work for Komen, I have had the joy of meeting and working with Rose Kushner who, as you may know, succumbed to breast cancer in January of this year. She encouraged me to get appointed to the National Cancer Advisory Board. It advises the National Cancer Institute.

My membership on the board has brought the research picture of this country into clear focus. Only 1 out of 6 grants will be funded in 1990. Old active research grants will continue to be used, so new researchers and their research could be assigned a back burner position. Not good for fighting this disease.

From 1989 to 1990, their budget for breast cancer research has gone from an actual $74.5 million to an estimated $77 million—a mere 3 percent increase. As I told you, the number of cases is increasing by at least 24 percent.

By the way, the Health and Human Services and the Office of Management and Budget have tentatively agreed to recommend a fiscal 1991 an additional $1.7 billion for AIDS research and public health programs. The numbers speak for themselves.

Basic science issues needing to be addressed are:

Do chemoprevention or hormonal prevention work?

Should a Tamoxifen trial be initiated?

Can we detect a blood-marker for fat to make an effective diet study possible?

What is the etiology of breast cancer in order to determine why the incidence rate is increasing so dramatically?

How does breast cancer metasticize and can we formulate a method to interfere with that process?

What makes a tumor become drug resistant so that we can devise therapies that if they do not cure a woman improve her chances for a longer life of acceptable quality.

Each one of these areas of inquiry is valid and vital. Limited funds force our scientists to struggle against each other over which projects should take priority. This is an incredible waste of their valuable time.

The National Cancer Institute is a crown jewel in the research community and it is essential that we continue to increase our support for its efforts, and particularly devoting more funds to breast cancer research.

The average years of life lost for breast cancer in females is 19 years. In a 1982 study done by Thomas Hodgson and Dorothy Rice, which was supported by the National Center for Health Statistics, entitled "Economic Impact of Cancer in the United States," an estimate of the total cost of cancer mortality was determined.

The updated version of this study states that in 1985, breast cancer mortality cost us $5.1 billion, or $128,000 per breast cancer death. This is quite a large investment. The 1990 figures will be even more incredible.

According to the National Coalition for Cancer Research, an economic savings of more than $170 million a year is being realized as a result of a National Institute of Health-sponsored study. The Federal research investment on this study was $11 million; and the return on the investment to date is 1,545 percent.

Please support this bill. Twenty-five million more dollars can make a huge difference; and it's going to make a difference in the lives of women like Susan Komen, in whose name a lot of this work is being done, who died an unnecessary death—not enough treatment, not enough was known, not enough state-of-the-art treatment, and certainly not enough research. And all of the 150,000 women this year who will be diagnosed with this disease, as they have been year after year after year, and 40,000 of those will die.

As Mrs. Quayle said, those are our mothers, our sisters, our daughters, our friends; and in my case, ourselves.

Thank you.

Ms. OAKAR. Thank you very much, Nancy.
[The prepared statement of Ms. Brinker follows:]

## PREPARED STATEMENT OF NANCY G. BRINKER

Good Morning, I am Nancy Brinker, the founder of The Komen Foundation. I appreciate the opportunity to testify on behalf of HR 3251, introduced by Representative Mary Rose Oakar.

It is very pleasing to follow my friend and colleague in the war against breast cancer, Marilyn Tucker Quayle. Let me offer my thanks to Marilyn and the Vice President for joining the RACE FOR THE CURE.

My sister died in 1980 of breast cancer at the age of 36. I, myself, contracted the disease in 1984. Her death inspired me to mobilize the private sector to support research on breast cancer.

According to the Center for Disease Control in Atlanta, the death rate from breast cancer in the United States in increasing. In 1986, the most recent year for which complete statistics are available, was 32.8 for every 100,000 women up for 31.1 in 1979. 44,000 deaths are expected in 1990. In those same seven (7) years, the number of new cases rose by 24%. That means 91 out of 100,000 women in 1979, 113 women out of 100,00 in 1986. There is no known reason for this dramatic increase.

The gravity of this disease make your support of increased funding for basic science essential. The cure or at least the control of breast cancer is going to come from the laboratory.

The Komen Foundation is a national organization based in Dallas that supports breast cancer research. Over the past eight (8) years, we have been able with the help of men and women across the country to raise over one million dollars for research projects. We fund fellowships to try to inspire the best bright minds to get involved in breast cancer research. This is a mere "drop in the bucket" but a public/private effort none the less.

In the course of my work for Komen, I had the joy of meeting and working with Rose Kushner who, as you may know, succumbed to breast cancer in January of this year. She encouraged me to get appointed to the National Cancer Advisory Board. My membership on that board has brought the research picture into clear focus. Only 1 out of 6 grants will be funded in 1990. Old active research grants will continue to be used, so new researchers and their work could be assigned a back burner position.

From 1989 to 1990 their budget for breast cancer research has gone from an actual 74.5 to an estimated 77.00 million dollars - a mere 3% increase. As I told you, the number of cases is increasing by at least 24%. (By the way, the Health and Human Services and the Office of Management and Budget have tentatively agreed to recommend a fiscal

1991 an additional $1.7 billion for AIDS research and public health programs.) The numbers speak for themselves.

The basic science issues are:

1. Do chemoprevention or hormonal prevention work? Should a Tamoxifen trial be initiated?
2. Can we detect a blood-marker for fat to make an effective diet study possible?
3. What is the etiology of breast cancer in order to determine why the incidence rate is increasing so dramatically?
4. How does breast cancer metasticize and can we formulate a method to interfere with that process?
5. What makes a tumor become drug resistant so that we can devise therapies that if they do not cure a woman improve her chances for a longer life of acceptable quality?

Each one of these areas of inquiry is valid and vital. Limited funds force our scientists to struggle against each other over which projects should take priority. This is an incredible waste of their valuable time. The National Cancer Institute is a crown jewel in the research community and it is essential that we continue to increase our support for its efforts now and when their full budget is considered by you this month.

The average years of life lost for breast cancer in females is 19 years. In a 982 study done by Thomas Hodgson and Dorothy Rice which was supported by the National Center for Health Statistics, entitled "Economic Impact of Cancer in the United States" an estimate of the total cost of cancer mortality in the United States was determined. The updated version of this study states that in 1985, breast cancer mortality cost the United States economy approximately $5.1 billion, or $128 thousand per breast cancer death. We must resolve to view breast cancer spending as an investment. The 1990 figures will be even more incredible.

According to the National Coalition for Cancer Research, an economic savings of more than $170 million/year is being realized as a result of a National Institute of Health-sponsored study of breast cancer. The federal research investment on this study was $11 million; the return on the investment to date is 1,545%.

Please support HR 3251. 25 million more dollars can really make a difference.

Ms. **Oakar**. Lynda.

## STATEMENT OF LYNDA CARTER

Ms. **Carter**. This subject can be very emotional for all of us.

First of all, my name is Lynda Carter. I'm an actress and I also like to think of myself as an activist on the issue of breast cancer.

I'm also co-chairman of the Race for the Cure, the June 16 run/walk in Washington, DC. My two fellow co-chairs are Loni Anderson and Larry Hagman. The 3 of us would like to raise a large amount of money for breast cancer prevention, detection, and treatment. We also want to raise public awareness about this terrible illness which, as you've heard, will strike 142,000 women this year.

I first got involved in the issue of breast cancer several years ago when I testified on the need for mammography to be included in the Catastrophic Illness bill; and most recently, when a close friend of mine was stricken and diagnosed with breast cancer.

When I first got the phone call from this very good friend of mine who happens to be an incredibly strong and vibrant woman with a wonderful career as a psychiatrist, and two healthy children, and a successful husband—she called me and she said: I have just discovered that I have breast cancer.

My first response, because I love this woman, was to cry. My second was to get angry. My third was to laugh at the incredible situation that we found ourselves in in a matter of moments, in a matter of days or hours between the time that she was just a normal, everyday person, my dear friend, and the time that she found out that she had breast cancer—an aggressive breast cancer. They found out there's lymph involvement, so her therapy with radiation and mammography was devastating to her and her family. It changed her whole outlook on life—I think a lot to the good. It changed my life as far as my perspective on life, and what things were important and what things weren't. That was the good that came out of it.

But the thing that struck me most poignantly was what if she hadn't had a mammogram? What if she hadn't had the breast exam that diagnosed very early breast cancer?

If she hadn't, today she would be walking around a condemned woman—condemned to death. She would be my good friend and we would be having dinner together, and we would be laughing and talking and going on with our busy lives, and she would be dying.

That is the position that millions of women are in all over this country; women my age, my sister's age, my friend's age—this pig in the python of the population—it's our people; it's our ages. First of all, they can be sophisticated, they can be uneducated; it doesn't make any difference. There's not enough education and public awareness on the need for mammography. It's still put under the rug. It's still avoided just because of inconvenience. And each one of us has to approach this as the devastating epidemic that it is, because any one of your children, or your sisters, or your mothers, could be walking around with a noose around their neck, in the name of breast cancer.

I doubt whether there's anyone in this room who hasn't [illegible] touched with breast cancer in some way—a mother, a [illegible] [illegible]nt, or a good friend. Some in this room have [illegible] cancer themselves.

I think it is safe to say that it has been devastating for all [illegible] Because, you see, breast cancer doesn't just affect women; it [illegible] them and can bankrupt them; and it can turn children into orphans, and husbands into widowers.

I get angry sometimes that there's so many things that we could be doing in this country to combat breast cancer. I'm sorry to say this, but if this were an illness that were striking mostly men at the rate that it is striking women, I think that society's response would be much more swift and much more dramatic.

Later in this hearing you will hear noted researchers talk about what needs to be done to speed the discovery for a cure for breast cancer, and certainly that is the ultimate goal of all of us testifying here today.

But there are some interim actions that we could take that would greatly improve the lives of women with breast cancer, or women at risk. One thing is mammography. The X-ray examination of breasts is an extremely effective method of early detection of breast cancer. But hundreds of thousands of women [illegible] country simply cannot afford this procedure, which [illegible] more than $100. Their health insurance, if they [illegible] enough to have any, will not pay for mammog[illegible] [illegible] for them. We tried last year, and [illegible] mammography part of Medicare—and [illegible] was repealed.

[illegible] need more public education about breast cancer, [illegible] self-exams, and about the illnesses of heredity character, [illegible] the National Cancer Institute's toll free hotline, which is [illegible] CANCER.

I am pleased that you are holding this hearing here today, Chairman Roybal, Chairman Oakar. We need your commitment to action—breast cancer is nothing short of an epidemic. When you're a woman my age, and your sex is so at risk—an estimated 1 in 9 American women will contract breast cancer in their lifetime—none of us can stand idly by and no one should stand idly by.

Thank you.

Ms. **OAKAR**. Thank you.

[The prepared statement of Ms. Carter follows:]

## STATEMENT OF LYNDA CARTER
## WASHINGTON, DC

Good morning. My name is Lynda Carter. I'm an actress but I also like to think of myself as an activist on the issue of breast cancer.

I'm co-chairman of the "Race for the Cure," the June 16 run/walk in Washington, DC. My two fellow co-chairs, Loni Anderson and Larry Hagman, and I want to raise a large amount of money for breast cancer prevention, detection and treatment. We also want to raise public awareness about this terrible illness, which will strike 142,000 women this year.

I first got involved in the issue of breast cancer when a close friend of mine was stricken with it several years ago.

I doubt whether there's anyone in this room whose life hasn't been touched by breast cancer in some way -- a mother, sister, aunt, good friend. Some in this room have battled breast cancer themselves. And I think it's safe to say that it's been devastating for all of us. Because, you see, breast cancer doesn't just affect women. It scars families and can bankrupt them. It can turn children into orphans and husbands into widowers.

I get angry sometimes because there are so many things we could be doing in this country to combat breast cancer. I'm sorry, but if this were an illness striking mostly men, I think society's response would be much more swift and dramatic. Later in this hearing, you'll hear noted researchers talk about what needs to be done to speed discovery of a cure for breast cancer. Certainly, that's the ultimate goal all of us testifying here today. But there are some interim actions we could take that [illegible] greatly improve the lives of women with breast cancer or [illegible] at risk.

For one thing, mammography, the X-ray examination of the breasts, is an extremely effective method of early detection of breast cancer. But hundreds of thousands of women around the country can't afford this procedure, which often costs more than $100. Their health insurance, if they're fortunate enough to have any, won't pay for mammograms, Medicare won't pay for them -- we tried last year and almost succeeded at making mammography a part of Medicare. Then the "catastrophic" bill was repealed.

We need more public education about breast cancer -- about breast self-exams, about the illness's hereditary character, and about the National Cancer Institute's toll-free hotline -- 1-(800)-4-CANCER.

I'm pleased you're holding this hearing today, Chairman Roybal and Congresswoman Oakar. We need your commitment to action. Breast cancer is nothing short of an epidemic. When you're a woman my age, and your sex is so at risk -- an estimated 1 in 9 American women will contract breast cancer in their lifetime -- you cannot stand idly by. No one should stand idly by. Thank you.

**Ms. Oakar.** Debbie.

## STATEMENT OF DEBORAH I. DINGELL

**Ms. Dingell.** Good morning. I'm testifying today in my capac[illegible] as Chairperson of the National Women's Health Resource Cent[illegible]

Madam Chairman and other members of the subcommittee, I thank you for this opportunity.

In the interest of time, I believe I will shorten my remarks but I would like to say a few things. I would like to heartedly endorse Nancy Brinker's and Lynda Carter's statements, which I agree with all of them—the 3 of us work very closely together on this issue. I am very proud to be their friend and I hope together we are able to make a difference some day.

Let me share with you some of the things that the National Women's Health Resource Center is doing in this Race for the Cure. The National Women's Health Resource Center is a nonprofit organization, which enables women to achieve and maintain healthy and productive lives by establishing a unique combination of programs that will identify their unmet health concerns. By creating a National Center of Excellence to promote professional education and women's health research, we are developing and providing model clinical services, especially those that will meet [illegible] needs of women who are currently underserved in the [illegible] field.

The Resource Center works with the public and [illegible] hance national advocacy efforts on women's [illegible] vide education and information that will [illegible] y an active role in their health care decisions.

This December, 5th, 6th, and 7th, the National [illegible] Resource Center, in conjunction with the National Institut[illegible] Child and Human Development, and the Behavioral Medicine Section of the National Institute of Mental Health, as well as the women doctors in NIH, is cosponsoring a National Scientific Conference entitled "Forging a Women's Health Research Agenda."

Four focus areas have been selected—breast cancer is the number 1 issue.

The purpose of the conference is to bring together nationally known scientific and medical professionals in order to discuss women's health research issues, and to identify what needs to be done to improve the status of women's health research in the Nation.

Position papers will be drafted by our multidisciplinary panel of experts. A press conference will be held on the third and final day in order to disseminate the valuable information to the public.

This conference has grown out of a need for more federally funded women-centered medical research. In 1987, the last year for which data is available currently, the NIH spent only 13.5 percent of their research budget on any women-related health issue. Often, doctors are prescribing therapies to women which have been tested on thousands of men and not one woman. It is unacceptable in this day and age that women's health research is not being given attention. Congress has got to start to pay attention. We are looking to change this.

A second symposium in the beginning of 1991 will focus on public policy issues. This conference will be instrumental in developing a "Women's Health Research Agenda" for the 1990s. We are working with the Women's Caucus on this.

Our desired outcome from these efforts is not only increased public awareness, which is critical, especially in the area of breast cancer, but also more coordinated research in increased funding.

As a fellow witness here today has said—Dr. Marc Lippman—if in the area of breast cancer we make the commitment to spend $3 to $5 million a year for 5 years, at about 6 centers nationwide, the chances of finding a cure are almost certain. The total cost is $30 million a year for 5 years, or $150 million.

When we look at all the other things we're spending money on, isn't this a priority, when it's the majority of population in this country that are affected?

I'm going to cut the rest of my remarks short in the interest of time, but I want to make one other statement.

The other thing that our group advocates—and I think it's very important that we look at—that every woman in this country has the right to a mammogram. And I think Congress, as you're looking at funding mechanisms for health care issues, has got to find a way to guarantee every woman in this country the necessary medical coverage and the necessary mammogram.

I want you to know I'm urging the chairman, who is chairman of the committee of authorization to do this, but it's going to take all of you to make it happen. I hope that you're able to do that.

I thank you for the opportunity to testify today.

[The prepared statement of Ms. Dingell follows:]

# TESTIMONY OF DEBORAH I. DINGELL
# BEFORE THE SUBCOMMITTEE ON
# HEALTH AND LONG TERM CARE
# SELECT COMMITTEE ON AGING

MAY 16, 1990

GOOD MORNING. MY NAME IS DEBORAH DINGELL. I AM DIRECTOR OF ADMINISTRATION AND STRATEGIC PLANNING AT GENERAL MOTORS AND CHAIR OF THE BOARD OF DIRECTORS OF THE NATIONAL WOMEN'S HEALTH RESOURCE CENTER, A SUBSIDIARY OF COLUMBIA HOSPITAL FOR WOMEN FOUNDATION, INC. I WOULD LIKE TO THANK THE CHAIRMAN, REP. OAKAR AND THE SUBCOMMITTEE FOR THIS OPPORTUNITY TO TESTIFY IN SUPPORT OF INCREASED FUNDING FOR BASIC RESEARCH INTO THE PREVENTION AND TREATMENT OF BREAST CANCER AND IMPROVED PUBLIC EDUCATION AND AWARENESS EFFORTS SURROUNDING THIS DEVASTATING DISEASE. LET ME SHARE WITH YOU WHAT THE NATIONAL WOMEN'S HEALTH RESOURCE CENTER IS DOING IN THIS RACE FOR THE CURE.

THE NATIONAL WOMEN'S HEALTH RESOURCE CENTER IS A NON-PROFIT ORGANIZATION WHICH ENABLES WOMEN TO ACHIEVE AND MAINTAIN HEALTHY AND PRODUCTIVE LIVES BY ESTABLISHING A UNIQUE COMBINATION OF PROGRAMS THAT WILL IDENTIFY THEIR UNMET HEALTH CONCERNS. BY CREATING A NATIONAL CENTER OF EXCELLENCE TO PROMOTE PROFESSIONAL EDUCATION AND WOMEN'S HEALTH RESEARCH, WE WILL DEVELOP AND PROVIDE MODEL CLINICAL SERVICES, ESPECIALLY THOSE THAT WILL MEET THE NEEDS OF UNDER-SERVED WOMEN. THE RESOURCE CENTER WORKS WITH THE PUBLIC AND PRIVATE SECTORS TO ENHANCE NATIONAL ADVOCACY

EFFORTS ON WOMEN'S HEALTH ISSUES AND TO PROVIDE EDUCATION AND INFORMATION THAT WILL EMPOWER WOMEN TO PLAY AN ACTIVE ROLE IN THEIR HEALTH CARE DECISIONS.

FOUR FOCUS AREAS HAVE BEEN SELECTED. BREAST CANCER, AN ISSUE TO WHICH I AM DEEPLY COMMITTED, HAS BEEN IDENTIFIED AS ONE OF OUR PRIMARY TARGETS. THIS DECEMBER, 5TH, 6TH, AND 7TH, THE NATIONAL WOMEN'S HEALTH RESOURCE CENTER, IN CONJUNCTION WITH THE NATIONAL INSTITUTE OF CHILD AND HUMAN DEVELOPMENT, AND THE BEHAVIORAL MEDICINE SECTION OF THE NATIONAL INSTITUTE OF MENTAL HEALTH, IS COSPONSORING A NATIONAL SCIENTIFIC CONFERENCE ENTITLED, "FORGING A WOMEN'S HEALTH RESEARCH AGENDA." THE PURPOSE OF THIS CONFERENCE IS TO BRING TOGETHER NATIONALLY RENOWNED SCIENTIFIC AND MEDICAL PROFESSIONALS IN ORDER TO DISCUSS WOMEN'S HEALTH RESEARCH ISSUES, AND TO IDENTIFY WHAT NEEDS TO BE DONE TO IMPROVE THE STATUS OF WOMEN'S HEALTH RESEARCH IN THE NATION. POSITION PAPERS WILL BE DRAFTED BY OUR MULTIDISCIPLINARY PANEL OF EXPERTS. A PRESS CONFERENCE WILL BE HELD ON THE THIRD AND FINAL DAY IN ORDER TO DISSEMINATE THIS VALUABLE INFORMATION TO THE PUBLIC.

THIS CONFERENCE GREW OUT OF NEED FOR MORE FEDERALLY FUNDED WOMAN-CENTERED MEDICAL RESEARCH. IN 1987, THE NIH SPENT ONLY 13.5% OF THEIR RESEARCH BUDGET ON WOMEN'S HEALTH. OFTEN, DOCTORS MUST PRESCRIBE THERAPIES TO WOMEN WHICH HAVE BEEN TESTED ON THOUSANDS OF MEN AND NO WOMEN. WE ARE LOOKING TO CHANGE THIS.

A SECOND SYMPOSIUM IN THE BEGINNING OF 1991 WILL FOCUS ON

PUBLIC POLICY ISSUES. THIS CONFERENCE WILL BE INSTRUMENTAL IN DEVELOPING A "WOMEN'S HEALTH RESEARCH AGENDA" FOR THE 1990'S. OUR DESIRED OUTCOME FROM THESE EFFORTS IS NOT ONLY INCREASED PUBLIC AWARENESS, BUT ALSO MORE COORDINATED RESEARCH AND INCREASED FUNDING. AS MY FELLOW WITNESS HERE TODAY, DR. MARC LIPPMAN, SO ELOQUENTLY STATES, IF IN THE AREA OF BREAST CANCER, WE MAKE THE COMMITMENT TO SPENDING $3-5 MILLION A YEAR FOR FIVE YEARS AT ABOUT SIX CENTERS NATIONWIDE, THE CHANCES OF FUNDING A CURE BECOME MUCH MORE CERTAIN (A TOTAL COST IS $30 MILLION A YEAR FOR FIVE YEARS, OR $150 MILLION.)

OUR "HANDS ON" EFFORTS IN THE RACE FOR THE CURE ARE COORDINATED THROUGH THE BETTY FORD COMPREHENSIVE BREAST CENTER WHICH OFFERS A FULL RANGE OF SERVICES INCLUDING BREAST CANCER SCREENING, DIAGNOSIS, FOLLOW-UP COUNSELING SERVICES AND COORDINATION OF NECESSARY TREATMENT. THE BETTY FORD COMPREHENSIVE BREAST CENTER HAS AN EXTENSIVE RESOURCE LIBRARY AVAILABLE TO THE PUBLIC. THE PROGRAM DIRECTOR, JUDITH MACON, R.N. DOES A TREMENDOUS AMOUNT OF BUSINESSES, AND HAS DEVELOPED A "BROWN BAG" LUNCH SERIES ON BREAST HEALTH. THE SERIES OFFERS INFORMAL DISCUSSIONS ON SUCH TOPICS AS "BREAST LUMPS: WHAT'S NORMAL: WHAT'S NOT," AND "MINIMIZING YOUR CANCER RISK THROUGH DIET." MS. MACON HAS BEEN SELECTED TO SERVE AS A PANEL MEMBER OF THE NIH CONSENSUS DEVELOPMENT CONFERENCE ON TREATMENT OF EARLY-STAGE BREAST CANCER NEXT MONTH. THE CENTER ALSO PRODUCES A QUARTERLY NEWSLETTER FOR PHYSICIANS, PROVIDING INFORMATION ON BREAST CARE ISSUES. THE CENTER'S BREAST CANCER SUPPORT GROUP IS DESIGNED TO ENHANCE EACH PARTICIPANT'S PHYSICAL, EMOTIONAL, AND

PSYCHOLOGICAL WELL-BEING DURING AND/OR AFTER TREATMENT FOR BREAST CANCER. INDIVIDUALS PARTICIPATING IN THE SUPPORT GROUP DISCUSS POSITIVE COPING STRATEGIES, SHARE RESOURCES, AND COPE WITH TREATMENT DECISIONS AND FOLLOW-UP CARE, THE IMPACT ON PERSONAL RELATIONSHIPS, AND MANAGING LIFE AFTER TREATMENT. WOMEN WITH BREAST CANCER SHOULD HAVE ACCESS TO ALL THE INFORMATION THEY WILL NEED TO HELP THEM FIGHT THIS DISEASE.

WE ARE PERHAPS MOST PROUD OF THE PROGRAM WHICH PROVIDES FREE MAMMOGRAMS TO LOW INCOME AND/OR UNDER-INSURED WOMEN IN THE WASHINGTON METROPOLITAN AREA, A PROGRAM DEVELOPED AS A RESULT OF GENEROUS FUNDING FROM THE MARGARET STEWART TRUST.

THE NATIONAL WOMEN'S HEALTH RESOURCE CENTER, THE BETTY FORD COMPREHENSIVE BREAST CENTER, THE COLUMBIA HOSPITAL FOR WOMEN MEDICAL CENTER AND THE AMERICAN CANCER SOCIETY ARE THE SPONSORS OF THE ANNUAL BREAST CANCER AWARENESS AWARDS. THIS LUNCHEON, FIRST HELD LAST YEAR, SERVES TO RECOGNIZE THOSE INDIVIDUALS WHO HAVE CONTRIBUTED TO IMPROVING THE QUALITY OF LIFE FOR WOMEN TOUCHED BY THE DISEASE. THE 1989 RECIPIENTS OF THE BREAST CANCER AWARENESS AWARDS WERE BELVA BRISSETT, A REACH TO RECOVERY VOLUNTEER, DR. KATHLEEN CANTWELL, INITIATOR OF THE BREAST CANCER DETECTION PROJECT, ELLEN KINGSLEY, A TELEVISION CONSUMER REPORTER AND PRODUCER WHO CHRONICLED HER OWN BATTLE WITH BREAST CANCER, AND YOUR ESTEEMED COLLEAGUE, THE HONORABLE MARY ROSE OAKAR, WHOSE TIRELESS EFFORTS SUPPORTING BREAST DISEASE PREVENTION PROGRAMS ARE WELL-KNOWN TO ALL. MS. SUSAN FORD BALES GAVE THE KEYNOTE

ADDRESS LAST YEAR. ADDITIONALLY, ROSE KUSHNER AND BETTY FORD WERE HONORED. PROCEEDS FROM THE LUNCHEON WERE DONATED TO THE AMERICAN CANCER SOCIETY. THIS YEAR'S BREAST CANCER AWARENESS AWARDS LUNCHEON WILL BE HELD ON OCTOBER 3RD IN WASHINGTON, D.C. AT THE WESTIN HOTEL.

ORDINARY WOMEN WHO SEE OTHER WOMEN IN THE SPOTLIGHT COPING WITH THIS DISEASE ARE THEMSELVES ENABLED TO CARRY ON THEIR LIVES AND ENCOURAGED TO DISCUSS THEIR TREATMENT OPTIONS.

THE NATIONAL WOMEN'S HEALTH REPORT PUBLISHED BY THE RESOURCE CENTER PROVIDES CURRENT ACCURATE HEALTH INFORMATION TO WOMEN ACROSS THE UNITED STATES. THIS NEWSLETTER IS AN IMPORTANT VEHICLE IN OUR NATIONAL EDUCATIONAL OUTREACH EFFORTS. BECAUSE THE PROSPECT OF A BREAST CANCER DIAGNOSIS IS SO FRIGHTENING, SOME WOMEN AVOID TAKING PREVENTIVE MEASURES. THROUGH ARTICLES RANGING FROM ACCEPTED MAMMOGRAPHY AND SELF-BREAST EXAM GUIDELINES TO PENDING LEGISLATION OF MAMMOGRAPHY COVERAGE THROUGH MEDICARE, WE ARE ABLE TO STRESS THE IMPORTANCE OF EARLY DETECTION WITH THIS DISEASE. WE SUPPORT LEGISLATION FOR MAMMOGRAPHY COVERAGE UNDER MEDICARE. KNOWLEDGE BRINGS EMPOWERMENT TO WOMEN WHO ARE FACED WITH THE LIFE-SHAKING DIAGNOSIS OF BREAST CANCER.

AND FINALLY, I AM PROUD TO SAY THAT VOLUNTEERS FROM THE NATIONAL WOMEN'S HEALTH RESOURCE CENTER WILL BE PARTICIPATING IN THE "RACE FOR THE CURE" ON JUNE 16TH. MY FRIEND NANCY BRINKER, FOUNDER OF THE SUSAN G. KOMEN FOUNDATION AND A NATIONAL ADVISOR TO THE RESOURCE CENTER IS THE IMPETUS BEHIND THIS SPECIAL RACE WHICH WILL RAISE MONEY FOR BREAST CANCER RESEARCH. WE NEED MORE PEOPLE LIKE NANCY TO FIGHT THE BATTLE. IF WE ALL DO OUR PART, THE RACE FOR THE CURE CAN BE WON. I THANK YOU FOR THE OPPORTUNITY TO SPEAK BEFORE YOU TODAY.

**Ms. Oakar.** Thank you very much, Debbie.

Isabel has graciously consented to wait for her testimony because we know you 3 have to be also at another meeting, so that we can ask some questions.

Let me ask, Nancy, you were a witness here 5 years ago when the statistics were even better relative to breast cancer and now more women are dying of it than ever before, 5 years later.

You are on the National Cancer Institute Advisory Board. As you mentioned; you succeeded Rose Kushner and she encouraged you to do that. Our statistics show that only 1 out of 6 of the peer review grants that are recommended for breast cancer research are funded, not because it's their fault—it's our fault, right—because they don't have the funds to give all the kinds of grants out—I recall a $60,000 grant for those women who took DES during their pregnancy, that couldn't even get funded, so that the doctor, the researcher, who could do the follow-up. I mean, can you believe?

You made an eloquent point of saying—and you have a private foundation—that you have raised hundreds of thousands of dollars for what's helped—but you have done it. But you are calling on us, I gather, as well, to combine efforts so that there truly is a private/public partnership on this issue.

Did I hear you correctly there?

**Ms. Brinker.** You heard me correctly.

I want to say that, truly, I believe that—and I know—that breast cancer is a high priority at the Cancer Institute. I also believe that our Director, Dr. Broder—who you will hear from in a while—is terribly committed to put whatever resources can be put towards this disease.

It is also my belief, as you pointed out, that we are at a funding crisis in this country. We are not going to be able to fund the young researchers who are going to give us answers. So many of the studies that will apply to breast cancer will be done from a very basic level that will also apply to other solid tumors—the funding is not there.

I think it is critical that we do forge private/public partnerships, as you have pointed out, Congresswoman. These partnerships are terribly important to keep the momentum going.

But I want to say again, and again, and again, private dollars can never reach and complete the work that needs to be done. As Debbie Dingell pointed out, the amount of funds that we have to commit to play catchup in this country are going to be enormous. We aren't able to fund some of these novel and new studies that come to the door, and come at our feet. Some of them won't be able to be funded for 2 to 3 years, which is a crime.

That's why I am so much in support of this additional $25 million being given.

**Ms. Oakar.** Thank you.

Debbie and Lynda suggested that—Debbie, when she cited the statistic, said that about 87 percent of the research at the Institute is done on men and not women. And we want the male-dominated diseases to certainly find—we want to find cures for those diseases. But it is a source of despair that this happens.

Lynda, you suggested that if this were a male-dominated disease, et cetera—but I'll tell you, from the men in this House whose wives have breast cancer, they become instant converts to bills like H.R. 3251, or 3864, the Rose Kushner Act, for mammography, et cetera.

Do you think we are going to get any men to run for the cure during this—

Ms. **Dingell**. I can tell you John Dingell is going to be there. And we want every man we can get in the House.

Ms. **Oakar**. He had better be, right?

Ms. **Dingell**. I promise you.

Ms. **Carter**. One of the issues as I spoke to my friend yesterday—this woman that I was talking to you about earlier—was that in this Race for the Cure she was going to another function, and she had bought 6 tickets to this function—and even this woman who has breast cancer was thinking of 5 women instead of 6 men.

Once again, I have to reiterate, the public education—and hopefully, breast cancer does not have to tragically strike your life in order for us to be aware of its problem and its effects.

Ms. **Oakar**. Tom.

Mr. **Downey**. No, why don't you take additional time?

Ms. **Oakar**. No, we're finished. I've finished my questions. I'm going to submit other questions for the record because I have a number of them.

I am delighted to have so many of my colleagues here. I think it's important that they are here so that they can get on board on some of these bills and get on key committees to help us—so we're delighted to have you here.

Mr. Downey.

Mr. **Downey**. Thank you, Mary Rose, and congratulations for your leadership.

I want to express my appreciation to the panelists; in particular, Ms. Carter made the point about this being something of a gender discrimination issue. I think one of the things you have to be concerned about—and I think Ms. Dingell made also an excellent point—is a sea of polite smiles and the nodding of heads; and as we leave the hearing room maybe some of us will participate in the run and maybe some of us won't participate in the run.

I would urge you, and I think Ms. Dingell alluded to this, to a new level of militancy so that we are not in a position to blithely ignore the lack of funding for a cure; or the point that you made, Ms. Dingell, about everyone being eligible for a mammogram.

It seems to me that all mothers in this country should also be—or potential mothers—entitled to prenatal care as well, so that the appalling reality of being 20th on the list of nations in infant mortality, and allowing 40,000 American infants to die every year, is a shocking statistic.

It is also shocking to me that women and their children constitute the lion's share of people who are poor in this Nation. These are not unrelated phenomena. The fact is that if you are not given an opportunity at the earliest moment of your life; if you are left, or abandoned, or divorced, you wind up being poor, is to me, a criminal neglect on the part of the Congress and the President.

I would only urge you—and I'm going to see if I'm free to run in the 5K race on the 16th—that you be more militant, and you be more outraged; and that you not only run, but you march here on Washington. Because, frankly, we have a budget crisis that is going to ignore the fundamental reality of the point that you're making today; and that is, that you can save money, and save lives, by this activity—not cost money. This is a short term investment that in the long term will save us a fortune, if you're just looking at it from an economic point of view, not from an emotional or psychological point of view.

As you pointed out, Ms. Carter, the devastation done to a family and to friends by this malady is easily documented.

I support these efforts. I think our spending priorities are completely inappropriate in this Nation; and I just urge you to a higher level of militancy and outrage so that you capture our attentions and not just our polite responses.

Ms. OAKAR. Thank you, Tom.

Mr. Regula, they have to leave and we have a vote.

Mr. REGULA. In the interest of time, I'll wait.

Ms. OAKAR. Mrs. Morella.

Mrs. MORELLA. I will be there to run for the cure. I'm very, very impressed that you've gotten together on this very, very important issue. In the interest of time I'll hold off, but I am cosponsor of the legislation.

Ms. OAKAR. Yes, I know you are. We need a lot of cosponsors for the legislation.

John.

Mr. MYERS. Thank you, Madam Chair, and I thank the ladies for their testimony here today.

I don't think cancer has a gender. There are different types of cancer, and every time a woman has breast cancer it touches many men, too. From my perspective I must say, honestly, I have always been concerned, but it's always been someone else who has had breast cancer. Not until January of this year did it hit my family. Since then I've had a new, real look at it and a more sincere concern about the research in the future than I have had before. Militancy sometimes gets you someplace, but care often gets a lot more, even with Members of Congress. So I suggest that you come forth with facts, and I'm certainly going to do my part.

I must say one thing about mammography—I certainly support it. But my wife faithfully had her mammograms every year and paid her money out. Yet, she had a mammogram on December 8 of 1989. And on January 10, 1990, in a biopsy, the doctors found a 9 centimeter breast tumor. That just didn't grow overnight. The technician or radiologist who read those mammograms didn't know what he or she was doing.

So I am on the stump making sure that women who go in faithfully for a mammogram should, for goodness sake, make that radiologist sign it. In my wife's case the gynecologist was a family friend; the radiologist called the gynecologist to say she's okay. On December 18th, the radiologist called the gynecologist, and he called my wife, and he said, you're okay but you've got to come in in about 6 months.

I brought her last 2 mammograms to someone here in Washington. An oncologist looked at them and said, We would have had her in here at least 2 years ago.

Radiologists, ladies—get the radiologist to sign your mammogram. And I think all radiologists ought to be licensed. We found the institution—the facility where my wife had a mammogram faithfully every year, was not certified by the American College of Radiology.

**Ms. OAKAR.** Will the gentleman yield on that point?

**Mr. MYERS.** Yes. I'm on the stump and—

**Ms. OAKAR.** No, you're absolutely right. H.R. 3864, and I'm sure Barbara's bill—

**Mr. MYERS.** I've read it.

**Ms. OAKAR.** —has protection; because you're absolutely right about the people. It's not that the mammograms are not important and helpful, and so forth.

**Mr. MYERS.** They certainly are, yes.

**Ms. OAKAR.** But you have to make sure that the proper technologist read them; and we can't be sloppy about that. We do have protection in that bill related to licensed practitioners and the kind of concerns you raise; and too many tragedies happened because of that.

**Mr. MYERS.** I'm a State's writer, as you well know. But in this instance, I'm for stronger controls. We license grain dealers, we license people who weigh grain, the people who grade meat—we license them. But a woman's life, we treat casually and say, well, he's a radiologist; he has an M.D. certificate hanging on the wall. Pap smears are the same way. We have some labs that are not doing a proper job, so I'm on the stump somewhat.

I've looked at that bill and I think we can put a little stronger teeth in it—I'm working on stronger language right now.

Ralph and I serve on the Appropriations Committee and we're looking into putting some more money into research. I must say to the ladies here, that I have a new concern, a new interest, and it has pushed me. Every woman who develops breast cancer—and, incidentally, men do too, but not as frequently as women—touches men's lives. Men are concerned; we have daughters, too. We're concerned about breast cancer and we appreciate your testimony this morning.

**Ms. OAKAR.** Helen, did you have a brief remark?

**Mrs. BENTLEY.** Very brief. Madam Chairman, I want to commend you for your continued activity in this field. You have been on this breast mammography testing and the breast cancer concern for a number of years now. I want to commend you and the panelists for what they've presented today.

I'm sorry I had other hearings that I had to attend, but this is a very important subject and certainly one that I agree with John Myers on. We will watch his bill—and I'm not on yours, I should be.

**Ms. OAKAR.** Thank you very much.

Debbie.

**Ms. DINGELL.** I just wanted to say that mammography still saves lives. And sometimes when people hear your story, they use that as an excuse. And the closing word, I would still like to say is, you're right, we need it certified—it's inexcusable what's happening in labs—that's a whole another story. But sometimes people hear that story; and I hear it day in and day out—well, they don't read it right so it doesn't save lives. Mammography saves lives.

**Mr. Myers.** I don't want to leave the impression that I would not suggest women have annual mammograms at age 35 or 40, depending on the family profile. But I do suggest that they get the technician to sign the mammogram. Doctors have to sign it and there are a few medical doctors here. If you had to sign a certificate verifying it's clear, you would be a lot more conscientious about putting your name on it, with malpractice suits and everything.

I am not going to sue anybody, our family isn't going to—that won't change anything. But I am going to stump in making certain that we improve the procedure, that those who read these mammograms take a deeper concern about the women's lives they're affecting.

**Ms. Brinker.** The things that you're bringing out are all very, very good and salient points. You need to know that we who are involved in educating patients—and certainly I know I speak for the Institute, we are looking all the time at ways to regulate and educate physicians and the patient population in what to expect in a good mammogram. And I think you will be seeing more of that as bills are passed with these regulations in them, and as patients become more educated. Your example's a very good one, but I think what Debbie is saying is also true. So, rest assured that things are moving in that direction.

**Mr. Myers.** I congratulate Nancy for your deep concern—and admitting it. So often when I think about my Indiana heritage, I think about the women who did not want to admit they had breast cancer—still don't today.

Marilyn Quayle was just in, as you saw—and for some reason in Indiana, we just don't want to admit that we have cancer. But people stepping forward who have experienced this will help other women, I think—and other men, too, who have cancer. I think we need to face it head-on and we need to talk about it.

I have encouraged my wife. We didn't put a press release out, but we've talked about it, and I think we should. I think we've got to encourage more women. We had an earlier witness, Mrs. Vucanovich, who at 61 had never had a mammogram. Money wasn't the issue; she could have afforded it. But her gynecologist never suggested she have a mammogram. So there is some educating we have to do, not only among the women, but among the gynecologists of the country. It's a big problem we have.

**Ms. Oakar.** Basically what you're trying to do is, number 1, increase public awareness by having the Race for the Cure, which is June 16. And the funds raised in that and the awareness will go to the Komen Foundation for the private sector, and the Nina Hyde Foundation; is that correct?

**Ms. Brinker.** Seventy-five percent of the funds will stay in the Washington area, benefiting projects here, and then the rest to the research fellowships that we give to labs all over the country.

**Ms. Oakar.** Because Washington has a tremendously high incidence of breast cancer.

Second, what you've suggested is that the public sector could do a lot better job, that we ought to have research increased for female-dominated diseases; that targeting breast cancers per se is very, very important; with limited funds you can do that and fund a lot of different grants that are not being funded because we want to cure.

And, third, we want preventive means because, as you've pointed out, you can save a lot of money by having a mammogram, and you can save a lot of lives—and that's the bottom line. I think we are all in agreement on those three or four points.

I really want to compliment all of you.

We are going to go vote and then we will come back to my friend who has done such a great job with the private sector as well; and our important researchers who are here as well.

Maybe what I will do is I'll stay since—there is an overwhelming vote on the rule—and I'll continue the presentations.

Thank you very much, good luck, have a nice luncheon.

Our next witness is Isabel Hammond, who is the Director of the American-Italian Foundation for Cancer Research.

Isabel, one of the things I was so surprised about when I went to your meeting in the winter was the number of people in the fashion industry and the varieties of industry who have taken a leadership position in trying to help with their dollars—foundation which you spread not only to the United States but throughout the world, because this is a worldwide problem.

I am so delighted that you were able to come in today from New York to talk to us about this issue. Please proceed in whatever way is most comfortable.

## STATEMENT OF ISABEL HAMMOND

Ms. **Hammond**. Thank you for inviting me to share this interesting meeting with you.

The American Italian Foundation for Cancer Research is a small organization founded by Professor Umberto Veronesi, Director of the National Institute of Cancer in Milan, who with Professor Gianni Bonadonna, of the same institute, pioneered the most advanced treatments of breast cancer. The Foundation is now 10 years old and operates in New York City

The Foundation philosophy is that cancer has no geographical or sociopolitical frontiers. The best way to fight cancer is through sharing information and spreading the available knowledge on ways to treat it.

The United States as a leader in medicine is looked upon by the world at large for leadership and guidance in the fight of the disease.

During a recent trip to Europe and North Africa I had another opportunity to experience the need for women for information about ways to deal with breast cancer. Just like in Indiana, as expressed by Mr. Myers, the word cancer is not openly mentioned. By demystifying its meaning and becoming aware of the importance for the patient to be informed, the fight becomes somehow easier.

I also learned of the difference in cost of some cancer treatments. For example in Caracas, Venezuela, a mammogram costs U.S. $10 to a private patient while in New York it can cost as much as $250. Something must be wrong with the pricing of this procedure in the USA. The same proportion applies to other procedures. We must eliminate waste and duplication. We must accept that there are innovative treatments in other parts of the world which are valid and implement them in our own midst.

Since cancer is really a multinational industry of mind-boggling proportions, we should figure out which components can be farmed elsewhere for cost-effectiveness, without detriment to results taking advantage of instant communication technology. Resources would be better used.

As to underutilization of facilities, I have an example. The Breast Cancer Center in Harlem, New York, is one of the best facilities I have seen anywhere. Yet it is only used by very few women, despite the fact that black women in Harlem are dying at a much higher rate than other black women elsewhere and much more than white women. The reason is that the center is only opened 3 days partially for lack of funds to pay the personnel. What a shame. Our foundation is conducting a free mammography screening in precisely that area of Harlem—which seemed a redundancy. At the completion of 2 weeks, our free screening for breast cancer program in Harlem, 572 women had had the test, to the astonishment of the directors of Harlem Hospital, New York Hospital and Sloan Kettering Cancer Institute.

The United States is still the leader in the fight against breast cancer. I hope it continues to be so. However, the lack of adequate funding might put this country behind other western areas of Europe, as they pull their own resources with much imagination and determination.

All facts and figures mentioned today are very significant and startling. Women in the USA are bombarded by bits and pieces which is all to the good, but few women fully understand the true meaning of the magnitude of the problem and the disproportion of funds allocated to research of breast cancer versus other types of research. It would be desirable to develop a communications system to bring the public up to date on what are still the big challenges in this fight.

I salute Nancy and her friends, particularly the leadership of Mrs. Quayle, in their initiative to make the Race For the Cure a national campaign. I propose that we make this campaign a world wide effort. This would really be a marvelous contribution of this country to this crusade. We should make it another Smoke Enders around the world.

Finally, the group I represent fully endorses and supports Ms. Oakar's initiative to obtain from the Congress of the United States an adequate budget for breast cancer research, and I am deeply grateful for the opportunity of sharing this important hearing with such distinguished guests.

Ms. OAKAR. Thank you very much, Isabel.

We will ask unanimous consent to put all the complete statements in the record.

I like your idea of having this an international event as well, and we will make sure that Nancy and others who are organizing this race have it.

I recall when I introduced the Informed Consent bill, which means simply that women ought to be told their options because I think there's a great fear that many people have about breast cancer is one reason why they don't get a mammogram. And, second, they worry about the treatment.

And as I recall, through the late, great Rose Kushner's kept feeding me this information—it was an Italian doctor who first did the study that found that lumpectomies were equally—depending on the size of the breast tumor—were equally as helpful in arresting the cancer as more radical surgery.

Then, of course, Dr. Bernard Fisher, in our country, did a case-by-case study of a very similar study.

But as I recall, that first initial study took place in Italy; am I right about that, Isabel?

Ms. **Hammond**. Absolutely. It was in the Milan Institute by Professor Veronesi and Dr. Gianni Bonnadona who at that time were partly financed by the National Cancer Institute. And they came to start our foundation in New York when those funds were being cut—and he couldn't stop his work. Luckily, Italy has rebounded enormously financially since then, and their financial needs are less evident than they were at the time our foundation was established. But it was Umberto Veronesi whose name is very well-known throughout the world who first demonstrated the validity of conservative procedures for the treatment of early breast cancer.

Ms. **Oakar**. So it's important to share information worldwide on this issue?

Ms. **Hammond**. Oh, yes, yes. For instance The European School of Oncology, founded also by Professor Veronesi, conducts courses, symposia and seminars worldwide, on the subject of breast cancer. These programs are led by the most renowned specialists from principal cancer centers in Europe and many from the USA, disseminating the latest knowledge on cancer treatments to doctors from countries where the advances are less known. The activities of this novel "traveling school" like in the Middle Ages, are tremendously successful. From instance, in the coming months, 5 courses on breast cancer will be conducted in 5 Latin American countries. The American Italian Foundation represents the school in the United States. Interaction and communications are essential.

Ms. **Oakar**. You work for the people in New York City, and I know you have a mammogram bill that—

Ms. **Hammond**. It is a very special project for our group. An annual mammography screening in poor areas of the city, free of charge. This year it will be in Harlem, where incidence of breast cancer and mortality there from is very high. We also have round table conferences on the subject of breast cancer. Our meeting in Venice last year gathered women from 15 countries who had had breast cancer. They wanted to talk about activism. Not all women feel like the American woman who openly demands clear information from the medical practitioner. Many women around the world are fearful, ignorant and very timid to approach the subject with a fighting spirit. Cultural differences and approaches to management of the disease make it desirable to develop a worldwide philosophy to effectively fight breast cancer. We came up with a "Bill of Rights of the Breast Cancer Patient."

And one episode was really memorable--the lady from Japan came to this meeting with her daughter, age 17. And this woman was very unabashed; unlike most Japanese ladies who are very reserved, she was very open and forward.

She said, in my country the daughter of a woman with breast cancer has a stigma because her potential for inheritance of the disease makes her suspicious. And we were all quite astounded. And the young lady stood up, and in perfect English—and then translated to French and Italian—explained how she felt about her mother having had breast cancer and how she felt about her future in Japan where this was such a stigma.

Then the lady from Finland said, we have no problem in Finland. We are constantly being screened for breast cancer —mammography is a matter of fact.

Then the lady from Greece would say, well, we have all the facilities at our disposal. However, in order for us to have an appointment we have to wait 6 months to be treated.

The gentleman from Russia—a guy who came from the Moscow Institute—he said, I have 10,000 women that I am monitoring—10,000 women—and I wish that you ladies would come to Moscow and tell these ladies about their rights; which brought us to produce in our foundation a small pamphlet that I'm delighted to leave with you, which is called "The Breast Cancer Patient's Bill of Rights." It's a compilation of some of the work being done before—certainly Rose Kushner was the spearhead of all of this idea; she is the mother of all of us. And no one will adequately remember her with enough awe and admiration and respect for what she did for us.

Ms. **Oakar**. I agree.

[The brochure follows:]

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# THE BREAST CANCER PATIENT'S BILL OF RIGHTS

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# THE BREAST CANCER PATIENT'S BILL OF RIGHTS

## THE RIGHT TO BREAST EXAMINATIONS

A woman has the right to a breast examination once a year, beginning with the onset of puberty.

She has the right to be taught breast self-examination by her physician.

She has the right to a baseline mammogram at age 40, unless there is a specific reason to perform it earlier.

She has the right to follow-up mammograms every two years after age 40, and every year after age 50, unless there is cause to perform them more frequently.

## THE RIGHT TO UNDERSTAND DIAGNOSTIC PROCEDURES

A woman has the right to a mammogram before any suspicious lump, thickening, redness or nipple discharge of the breast is biopsied for comparative purposes.

She has the right to sign a statement of informed consent before a biopsy is performed.

She has the right to expect that no further surgical treatment will be undertaken in conjunction with a biopsy unless there is a medical counter-indication.

## THE RIGHT TO ASK QUESTIONS

A woman has the right to ask questions of her physician, and to receive helpful and informative answers.

## THE RIGHT TO COMPASSIONATE CARE

A woman has the right to compassionate care and support that will insure her physical, emotional and spiritual well-being.

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## THE RIGHT TO INVOLVE THE FAMILY

A woman has the right to include her family in the decision-making process. If she is not able to make decisions for herself, she has the right to appoint a family member, or other individual, to act in her behalf.

## THE RIGHT TO INFORMATION CONCERNING TREATMENT

A woman has the right to a complete medical evaluation before any treatment is initiated.

She has the right to know the risks, benefits and side effects of any suggested treatment.

She has the right to seek a second opinion from another physician at any point in her medical treatment.

She has the right to be informed of the different modes of available treatment, including surgery, radiotherapy, chemotherapy, immunotherapy and hormonal therapy.

She has the right to know if the suggested treatment is experimental in nature, or if she is participating in a random study.

She has the right to refuse treatment, or to withdraw from a study, without being abandoned by her physician.

She has the right to follow-up medical examinations by her physician on a regular and timely basis.

## THE RIGHT TO ANCILLARY CARE

A woman has the right to seek out cancer support groups or to request individual psychological assistance.

She has the right to information concerning breast reconstruction if a mastectomy is indicated.

## THE RIGHT TO BE PAIN FREE

A woman has the right to receive adequate relief from pain related to surgery, therapy, or the advancement of the disease itself.

She has the right to whatever drugs or therapies are necessary to obtain pain relief, without regard to addiction, in case of advanced disease.

## THE RIGHT TO MEDICAL RECORDS

A woman has the right to a written pathology report, as well as her slides and medical records, for use in a second opinion.

## THE RIGHT TO CONFIDENTIALITY

A woman has the right to expect that her medical condition will be discussed only by those who are directly involved with her care.

## THE RIGHT TO HEALTH INSURANCE

A woman has the right to ongoing health care coverage despite the diagnosis of breast cancer.

## THE RIGHT TO EMPLOYMENT

A woman has the right to continued employment regardless of her diagnosis.

## THE RIGHT TO HOPE

A woman has the right to continued care by her physician whether or not further treatment is indicated.

## THE RIGHT TO THE QUALITY OF LIFE

A woman has the right to be treated as a whole person – not a disease or a statistic.

She has the right to decide the extent of procedures administered in the event that she is hopelessly ill.

**Ms. HAMMOND.** But we want to make this little brochure available—not only to the women in America, but women elsewhere—adjusted to the local cultural socioeconomic conditions.

So I feel that being part of the American dream in the field of medicine, specifically the field of breast cancer fight is very exciting. I think you ladies have a great element at your hands which is your credibility and your power; in other parts of the world it is not so. But it will develop if you continue it. And you are paving the way to make all these wonderful programs more valid and so much more effective.

Thank you.

**Ms. OAKAR.** Thank you very much, Isabel.

As you know, we can't do it without the men, and we're delighted to have the leadership of many of the men in Congress on this issue and other issues.

John, did you have a question for Isabel?

**Mr. MYERS.** No. I'm sorry that I had to miss part of your testimony but I will read it.

**Ms. HAMMOND.** I can go out on that because I sense that you have accepted the picture—you spoke about originality, about confidentiality, about timidity, about inadequacy of the technical analysis. All of these are key issues in the effective care of breast cancer. And essentially what Mary Rose is doing is extraordinary, and we can't work without the funds. But quality control is essential.

**Mr. MYERS.** It certainly is. It is especially true when we are talking about people's lives.

**Ms. HAMMOND.** Absolutely.

**Ms. OAKAR.** That's right.

**Mr. MYERS.** I have become an authority in the last 4 months—I've read much more than I wish I had.

**Ms. HAMMOND.** Well, some day it will be your turn to do the same for prostate cancer.

**Mr. MYERS.** I hope not.

**Ms. HAMMOND.** In the terms of coming out of the closet and treating it as well.

**Mr. MYERS.** I think this is very true.

As I say, in Indiana, for some reason, women just don't want to talk about it. People come up and tell my wife they had this 10, 12, 14 years ago. She never dreamed—it's always shhhh. And people come up to me and kind of sidle up and say, How's your wife (whispering)?

I say, Oh, she's fine, and she's taking chemotherapy (speaking louder).

Oh, do you want to talk about it?

I say, sure.

Maybe we should have put a press release out. It's one of those things, you know, that you're not happy about. Even though in the press releases, I'm pleased about accomplishment. And at this point we're working on it seriously and doing everything we can. I say "we,"—not so much "I."

**Ms. HAMMOND.** Well, we depend on you. As I said, not only American women—women around the world.

Mr. **Myers**. Cancer is—especially breast cancer—an emotional problem as well as physical. More so in my case right now with my wife, it's more emotional than it is physical.

So I think that everyone who is here contributes; but the big thing I think we need to do is to bring it out in the open, hit it head-on, and start clipping it.

Ms. **Hammond**. Of course.

Mr. **Myers**. Not hide it, like you say, that in some cultures they won't even talk about it—and then it happens.

Ms. **Hammond**. I was in Morocco last week in Marrakesh, and I went to somebody's house—a simple person who invited me to her house. And I arrived in that house and found 6 women, doing nothing; 3 of them in their forties, maybe early thirties; no teeth; 2 absolutely gorgeous young girls. And one was not seen. So I asked the person where is so and so?

Oh, she's not available.

In the course of the luncheon I discovered that she was sick. Eventually I went to see her, like 1:30—she had breast cancer, and nobody wanted to talk about it.

It pained me so because she wasn't being treated either; and it probably was terribly advanced by the time they finally got her to some very primitive facility. But there it is.

Mr. **Myers**. You mentioned the international concern and interest. We are working on a program in Moscow right now with the Soviet Union with the thousands of girls and women who were subjected to radiation from the Chernobyl nuclear accident. It has not been finalized yet—but one is prevention and one is to study the incidence. We are working on that program and we have some good indications that we will have some accomplishment—I hope it will help in our research in this country too.

Ms. **Hammond**. Absolutely, yes.

Mr. **Myers**. We have a big opportunity here, as you mentioned.

Ms. **Hammond**. They are really very, very eager for help. On June 22nd there is a seminar and press conference conducted by the European School of Oncology—Professor Veronesi—on this country, Moscow. I plan to attend and I will send you whatever information I can find.

Ms. **Oakar**. Then we will put it in our record, Isabel. Thank you very much.

Mr. **Myers**. Appreciate that, thank you.

Ms. **Oakar**. Thank you very much, John.

Thank you, Isabel, very much, and please extend my greetings to all your associates.

Ms. **Hammond**. Thank you, dear.

Ms. **Oakar**. We have another panel now: Dr. Samuel Broder, who is the Director of the National Cancer Institute. We've been talking about your Institute for a while now.

Dr. Marc Lippman, who is the Director of the Vincent Lombardi Cancer Research Center at Georgetown University Medical Center, and the past head of the Medical Breast Cancer Section of the National Cancer Institute.

Dr. Maureen Henderson, who is the head of the Cancer Prevention Research Program of the Fred Hutchinson Cancer Research Center in Seattle, Washington.

And Mr. Harvey Kushner, who is the, among other things, the husband of the late, great Rose Kushner that we've all been talking about. I'm sure her ears are burning because she was the witness of our subcommittee twice, and was the inspiration for my getting involved in this issue, among other people.

Rose was, of course, a strong advocate for breast cancer victims and a member of the Board of Directors of the National Alliance of Breast Cancer Organizations.

We are delighted to have all four of you here.

Dr. Broder, please proceed in whatever way is most comfortable. We are honored that you could come and we're sorry that you've had to stay so long. We're a little late in getting started on this panel but we'll try to make up for lost time.

## STATEMENTS OF SAMUEL BRODER, M.D., DIRECTOR, NATIONAL CANCER INSTITUTE, BETHESDA, MD; MARC E. LIPPMAN, M.D., DIRECTOR, VINCENT T. LOMBARDI CANCER RESEARCH CENTER, GEORGETOWN UNIVERSITY MEDICAL CENTER, WASHINGTON, DC; MAUREEN M. HENDERSON, M.D., HEAD, CANCER PREVENTION RESEARCH PROGRAM, THE FRED HUTCHINSON CANCER RESEARCH CENTER, SEATTLE, WA; AND HARVEY KUSHNER, ADVOCATE OF BREAST CANCER VICTIMS, AND CHAIRMAN, BOARD OF DIRECTORS, BREAST CANCER ADVISORY CENTER, KENSINGTON, MD

### STATEMENT OF SAMUEL BRODER

Dr. **Broder**. Congresswoman Oakar, with your permission, I'd like to read an opening statement.

Ms. **Oakar**. Absolutely.

Dr. **Broder**. It's my very great honor to testify here with the distinguished panelists that have included Mrs. Marilyn Quayle, Mr. Harvey Kushner, Ms. Nancy Brinker, and the very distinguished other panelists who have been here.

My special greetings to Congressman Myers—it's good to see you again.

This panel of witnesses includes formidable and effective patient advocates for breast cancer research, prevention, and treatment.

Perhaps I could say that one person who is not here physically, but who is here in spirit: I am referring to Rose Kushner, who was one of the most persuasive and expressive advocates for women with breast cancer.

I have also had the special pleasure of working with Nancy Brinker, who is an effective and active member of our National Cancer Advisory Board. And to my left is one of my acolytes, Dr. Marc Lippman, who probably has learned everything he knows from me.

NCI has a vigorous program of breast cancer research. We have successes, but we need much more research and we have the challenge of seeing that this research is applied to the benefit of all American women. We are now involved in an intense effort to shorten the time between discovery and application, between laboratory and bedside advances, and I believe that we are making progress in doing this.

Success in breast cancer research requires a broad array of services and programs including all 3 foundation stones of the NCI, which include: (1) basic research; (2) our Cancer Centers program and; (3) clinical trials. We need an effective balance of these 3 foundation stones to support our Institute.

In the United States this year, approximately 150,000 women will be diagnosed with breast cancer and approximately 44,000 will die of their disease. There is no question that this is one of the Nation's leading health problems. Breast cancer and lung cancer are leading women's health issues.

The death and suffering caused by breast cancer is also a family issue. Breast cancer can disrupt families and can have indirect but profound effects on children and young people.

First, I would like to mention research and programs on early diagnosis and screening. Mammography is among the most effective ways to diagnose early breast cancer, a time when it is most readily treatable. Scientists estimate that breast cancer deaths could be reduced by at least 30 percent if women followed the National Cancer Institute's guidelines for mammography.

NCI and a number of other medical organizations have agreed on certain guidelines for mammograms; and we generally believe that women starting at age 50 should have an annual clinical examination and a mammogram.

NCI scientists are meeting with members of the Electronics Industry Foundation to try to stimulate the development of improved, more portable, and more cost-effective mammography units which would help in screening women who have difficulty in gaining access to mammography units. This is an example of our governmental/private sector cooperation.

NCI reaches out to American women in a number of ways. The Office of Cancer Communications maintains an active stream of programs and activities designed to find new ways to carry the messages of prevention, early detection, and treatment of breast cancer.

Last September, the Women's Leadership Summit on Mammography, sponsored by the Komen Foundation and the National Cancer Institute, was held here on Capitol Hill. We were very grateful for the support and participation of Congresswomen Oakar Vucanovich and others in Congress on that occasion. We were honored to have the First Lady, Mrs. Barbara Bush, give the keynote address. Secretary Louis Sullivan and Under Secretary Constance Horner of the Department, and over 200 women, prominent in businesses, communities, or other organizations, came to spearhead drives for more mammography initiatives.

This event served to kick off NCI's Breast Cancer Screening Education Initiative.

I cannot help but note and remember that Nina Hyde co-chaired that meeting and spoke on that occasion and set an example of grace under adversity that can hardly be equaled. Nor can I forget that Rose Kushner was there, very much surrounded by her friends, and very much providing spiritual leadership. They are no longer with us, but we have not forgotten their contributions.

A second breast cancer summit, which will be focusing on new therapies and the application of existing therapies, is being planned for late January 1991, although this date is not finalized. I am sure that you will be hearing more about this as time grows closer.

The NCI Breast Cancer Screening Education Initiative reaches women and health care professionals, provides materials for public education, and encourages physicians to recommend mammograms for screening.

Members of the public can easily find the best information about breast cancer by calling the toll free 1-800-4-CANCER number to reach the NCI's Cancer Information Service. By making one phone call, a woman or a family member, anywhere in the country, can learn basic facts about breast cancer and mammography, gain access to top-flight medical institutions and, state-of-the-art treatment information, and learn how to gain entry into an NCI-clinical trial. It is important that participation in NCI-sponsored state-of-the-art clinical trials be encouraged for women in all walks of life, rich or poor.

I want to tell you about the basic science, prevention, diagnosis and treatment research being carried out by the NCI scientists who work in our program—I must be brief and I will necessarily skip many areas of interest.

Our primary goal is to understand the causation of breast cancer and to learn to prevent and cure this disease. Researchers in a number of projects are examining the relationship between dietary, nutritional, and lifestyle factors and breast cancer with the goal of preventing this disease.

Reaching out to the consumer, NCI has a National Supermarket Collaborative Project designed to help shoppers learn to select foods that might reduce their risk of cancer. One chain, located largely in inner city areas, is collaborating in this study and will reach many women, particularly women who are minority group members.

A joint United States-Finland study of nutrition and cancer is examining the role of fats, selenium, and vitamins A, E, and C in breast cancer development or suppression.

I bring this up as one example of some of the international collaborations which the Institute undertakes in the context of the previous discussion by earlier panelists.

We are very interested in the role of fat or other nutritional factors as potential causes of breast cancer in some women.

Although I began by discussing prevention, much of the research that we need to do in all walks of cancer development is supported by basic research, which in a sense, must come first. Basic research has elucidated the character and role of oncogenes and suppressor genes which play important roles in the development of or inhibition of cancer, including breast cancer.

The role of various factors and proteins in metastastic spread—that is the process by which cancer goes from an original site throughout the body—is now better understood, and new methods are in view which could interfere with this deadly process.

More accurate predictors of relapse or survival in patients with breast cancer are needed and, fortunately, through basic research, we are on the track of some of these important markers. A research effort is under way to identify genes or families of genes that predispose women in high-risk families to breast cancer.

Molecular markers for breast cancer risk and prognosis are moving closer every day to clinical applications. A protein produced by what is called the HER-2/neu oncogene, a gene which appears to be linked to breast cancer, is sometimes present in patients whose tumor has spread to other parts of their body. Early laboratory studies indicate that this gene marker may help us predict those women who could undergo metastastic involvement; and might help us pinpoint patients who would benefit from more intense treatment.

The presence of many copies of another gene, which is called c-myc, also has prognostic value.

NCI scientists are conducting very exciting research on metastasis—once again, this process by which the tumor spreads. A gene referred to as nm23, has been recently discovered. This gene suppresses metastastic events and defects in or absence of this gene have been linked with highly metastastic breast cancer. In theory, it will be possible to replace this gene or the protein it produces and prevent metastastic involvement.

In general, it is the metastastic spread of breast cancer which kills a woman.

Laboratory studies have also found that the presence of a special protein marker—some of them are called cathepsin D—and related types of markers, can identify women who are more likely to recur.

Monoclonal antibodies, immune system proteins that "home in" on and bind to specific cancer cells, are being developed for the early detection and treatment of breast cancer.

What about treatments that are available at hand?

Progress continues as new approaches to treatment are developed. We are making progress on a number of fronts, including adjuvant therapy, which involves the treatment of patients at the time of surgery.

We are conducting a number of clinical trials throughout the country; many of these are testing hormonal interactions.

We are looking for ways of intensifying breast cancer treatments, including novel ways of replacing bone marrow, and special ways of replacing stem cells from peripheral blood so that women can get higher doses with less side effects.

NCI-supported scientists are developing a number of approaches to handle the problem of multi-drug resistance. Many patients respond to breast cancer therapies at the beginning, but then the tumors to respond later on—and we are learning the molecular biology of this process.

We are looking at complex issues such as the effect of DES and estrogen on cancers. We are focusing on age-related changes that occur and the role that they play in cancer. Women over age 65, in our definition, represent an underserved population and we will try to repair this issue.

I would like to end by stressing our obligation to reach underserved populations. We need to make sure that all of the technologies that are part of the National Cancer Institute that are developed by any of its funding instruments reach underserved and impoverished women throughout the country.

Breast cancer is a significant problem among black women and NCI has begun an initiative addressed to both young and older black women. Studies show a higher than expected breast cancer rate for young black women and lower survival rates for black women of all ages taken as a group.

We are also pursuing relevant treatment, screening, and prevention technologies for Hispanic women, and we are making expanded efforts to make sure that our activities are culturally relevant, because we cannot assume that our information systems or the other activities which we support will be automatically culturally appropriate for certain minority groups and for Hispanic populations.

Similar approaches are under way for Native Americans, including Alaskan Natives and Native Hawaiians.

In conclusion, we need to continue our research, education, training, and communication efforts. We need to reach women from North Dakota to Louisiana, from Harlem in New York to Harlan County in Kentucky. It will take all of our skills, all of our drive to do this. Words will not accomplish this; a commitment to the infrastructure and resources of the Institute will.

We at NCI appreciate the concern of the Congress and of this committee, and the galvanizing courage of patient advocates such as those with us today.

I thank you for the privilege of being here.

Ms. **OAKAR**. Doctor, thank you very much.

We are going to continue, and save our questions after the panel is completed.

[The prepared statement of Dr. Broder follows:]

STATEMENT BY

SAMUEL BRODER, M.D.

DIRECTOR

NATIONAL CANCER INSTITUTE

**NATIONAL INSTITUTE OF HEALTH**

**PUBLIC HEALTH SERVICE**

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**Before the**

**House Select Committee on Aging**
**Subcommittee on Health and Long Term Care**

**May 16, 1990**

It's my very great honor to testify here with Mrs. Marilyn Quayle, Mr. Harvey Kushner, Ms. Nancy Brinker, and Ms. Isabel Hammond. This panel of witnesses includes formidable and effective patient advocates for breast cancer research, prevention, and treatment.

Perhaps I could say that one person who is not here physically, is here in spirit: I am referring to Rose Kushner, who was one of the most persuasive and expressive advocates for women with breast cancer. I have had the pleasure of working with Nancy Brinker who is an effective and active member of our National Cancer Advisory Board.

I am pleased to see Dr. Lippman as well as we were long-term colleagues at NCI.

NCI has a vigorous program of breast cancer research. We have successes, but we need to do much more research and we have the challenge of seeing that this research is applied to benefit all American women. We are now involved in an intense effort to shorten the time between discovery and application, between laboratory and bedside and I believe that we are making progress in doing this.

Success in breast cancer research requires a broad array of services and programs including all three foundation stones of the NCI: basic research, Cancer Centers, and clinical trials. In the United States this year, 150,000 women will be diagnosed with breast cancer and 44,000 will die. Breast cancer incidence increases sharply with age up to the time of menopause and continues to rise thereafter. There is no question that this is one of the nation's leading health problems. Breast cancer and lung cancer are leading women's health issues.

The death and suffering caused by breast cancer is also a family issue. Breast cancer can disrupt families and can have indirect but profound effects on children and young people.

First, I would like to especially mention research and programs on early diagnosis and screening. Mammography is among the most effective ways to diagnose early breast cancer, a time when it is most easily treated. Scientists estimate that breast cancer deaths would be reduced by at least 30 percent if women followed the National Cancer Institute's guidelines for mammography.

NCI and 10 other medical organizations have agreed on guidelines for mammography: we particularly urge that starting at age 50, every woman should have an annual clinical examination and a mammogram. NCI scientists are meeting with members of the Electronics Industry Foundation to try to stimulate the development of improved, more portable, and more cost-effective mammography units which would help in screening women who have difficulty in gaining access to mammography units.

NCI reaches out to American women in a number of ways. The NCI Office of Cancer Communications maintains an active stream of programs and activities designed to find new ways to carry the messages of prevention, early detection, and treatment of breast cancer.

Last September, the Women's Leadership Summit on Mammography, sponsored by the Komen Foundation and NCI, was held here on Capitol Hill. We were very grateful for the support and participation of Congresswomen Oakar and Vulcanovich and others in the Congress on that occasion. We were honored to have the First Lady, Mrs. Barbara Bush, give the keynote address. Secretary Louis Sullivan and Undersecretary Constance Horner urged the over 200 women, prominent in businesses, communities, or organizations who attended, to spearhead drives for more mammography. This event served to kick-off NCI's Breast Cancer Screening Education Initiative.

I cannot help but remember that Nina Hyde co-chaired the meeting and spoke on that occasion and set an example of grace under adversity that can hardly be equaled. Nor can I forget that Rose Kushner was there, very much surrounded by her friends. They are no longer with us, but we have not forgotten their contributions.

A second Mammography Summit is being planned for November 8, 1990, and I'm sure you will be hearing more about that as the time grows closer.

The NCI Breast Screening Education Initiative reaches to women and health care professionals, provides materials for public education, and encourages physicians to recommend mammograms for screening.

Members of the public can easily find the best information about breast cancer by calling the toll free 1-800-4-CANCER number to reach the NCI's Cancer Information Service. By making one phone call a woman or a family member, anywhere in this country, can learn basic facts about breast cancer and mammography, top-flight medical institutions, state-of-the-art treatment information, and how to gain entry in a NCI-clinical trial. It is important that participation in NCI-sponsored state-of-the-art clinical trials be encouraged in all walks of life, rich or poor.

I want to tell you about the basic science, prevention, diagnosis and treatment research being carried out by NCI-supported scientists, but I know that I must be brief and I will necessarily skip many areas of interest.

Our primary goal is to understand the causation of breast cancer and to learn to prevent and cure this disease. Researchers are examining the relationship between dietary, nutritional, and lifestyle factors and breast cancer with the goal of preventing the disease. Some examples are:

- A 6 to 10 year cohort study of diet and its relationship to breast cancer and other major cancers, among older Americans is being started.

- Another study is under way to determine aspects of the Western diet associated with breast cancer risk in American women of Asian ancestry, and to evaluate whether dietary factors during childhood and adolescence are crucial risk factors.

- Feasibility studies are underway to aid in designing a large scale trial of the effects of dietary change on cancers, especially breast cancer, and on cardiovascular disease.

- Reaching to the consumer, NCI has a National Supermarket Collaborative Project designed to help shoppers learn to select foods that reduce their risk of cancer. One chain, located largely in inner city areas, is collaborating in this study and will reach many women, particularly women who are minority group members.

- A joint United States-Finland study of nutrition and cancer is examining the role of fats, selenium, and vitamins A, E, and C in breast cancer development or suppression.

- A three-year investigation of the possible role of oral contraceptives, alcohol, and diet as risk factors for breast cancer in women was launched in 1989. About 5,000 women from across the United States will be involved in the study, which mainly focuses on determining the influence of hormones and other factors on breast cancer risk.

- We are very interested in the role of fat or other nutritional factors as potential causes of breast cancer in some women.

Although I began by discussing prevention, much of that research is supported by basic research, which in a sense, comes first. Basic research has elucidated the character and role of oncogenes and suppressor genes which play important roles in the development of or inhibition of cancer. The role of various factors and proteins in metastasis, the process by which cancer spreads, is now better understood and new methods are in view which could interfere with this deadly process. More accurate predictors of relapse or survival in patients with breast cancer are needed and fortunately, through basic research, we are on the track of some of these markers. A research report is under way to identify a panel of genes that predispose women in high-risk families to breast cancer.

Molecular markers for breast cancer risk and prognosis are moving closer every day to clinical applications. For instance, a protein produced by the her-2/neu oncogene, a gene which appears to be linked to breast cancer, is sometimes present in patients whose tumor has spread to other parts of their body. Early laboratory studies indicate that this gene-maker may be a predictive sign of metastasis and would help to pinpoint patients who would benefit from more intense treatment. The presence of many copies of another gene, the c-myc gene, also has prognostic value.

NCI has very exciting research on metastasis and a gene, nm23, has been discovered that suppresses metastasis. Defects in or absence of this gene have been linked with highly metastastic breast cancer. In theory, it will be possible to replace this gene or the protein it produces and prevent the metastasis.

Laboratory studies have also found that the presence of a special protein called cathepsin D is a sign that a woman's tumor is more likely to recur. This research will help further the development of a test to detect the proteins which will, once again, help identify patients who would benefit from more intensive treatment after surgery.

Monoclonal antibodies, immune system proteins that "home in" on and bind to specific cancer cells, are being developed to detect and treat breast cancer. Such monoclonal antibodies can locate microscopic breast cancer cells, and will certainly improve diagnosis and clinical management in the future.

What about treatment? Progress continues as new approaches to treatment are developed. Quality of life during treatment is a crucial issue. Today, as a result of research, we know that breast-sparing surgery--lumpectomy followed by radiation--can be effective as mastectomy for patients with early-stage breast cancer.

Adjuvant therapy for breast cancer is an active approach to preventing recurrence of breast cancer. Adjuvant therapy means that we start certain drugs or hormones right after surgery, and that we don't wait for the tumor to reappear in visible form. Clinical trials carried out all over the country with thousands of patients have proven that many women with breast cancer may benefit from adjuvant chemotherapy or hormonal therapy after surgery.

Clinical researchers are studying combination hormonal therapies to determine if they are more effective than single hormones used sequentially. Another approach is using hormones to "prime" cancer cells to make them more susceptible to cancer drugs. All in all, hormonal therapies are very useful and promise to be even more useful in the future for breast cancer patients. Many forms of therapy involve a special hormone-inhibition drug called tamoxifen. One question of interest ot many scientists is whether tamoxifen could lower the risk of breast cancer if given to high-risk women as a prevention measure.

One new approach to treatment of breast cancer is to intensify, that is, increase, dosage to maximize the killing of breast cancer cells. However, these high dose treatments affect the bone marrow and can cause death. Now new biologic treatments using colony stimulating factors essentially help "rescue" the patient's bone marrow and aid recovery from these intense treatments. Clinical researchers are helping breast cancer patients receiving very high doses of chemotherapy, by taking their bone marrow cells and storing them; then, after very high doses of chemotherapy, reinfusing them into a peripheral vein. The returned cells then repopulate the patient's bone marrow cavities and allow red and white blood cell recovery from very intensive dose of chemotherapy.

NCI-supported scientists have now found a way to harvest bone marrow stem cells not from the bone itself, but from peripheral blood of the patient. Colony stimulating factors, growth factors that are genetically engineered, are used to stimulate increased numbers of stem cells to repopulate the bone-marrow and help the patient's recovery. Early results suggest that these bone marrow cells from the peripheral blood are capable of repopulating a patient's bone marrow cavity in as few as 7 days, in some cases, even after very high doses of chemotherapy.

Multidrug resistance is a problem that limits the effectiveness of anticancer drugs in certain patients. New breast cancer studies are finding that using alternating combinations of drugs may help keep tumors from becoming resistant to the drugs.

Let me stress that the overall health of women concerns us in addition to the specific issue of breast and other cancers. We are looking at complex issues such as the effect of DES and estrogen on cancers, the balance between treating for one problem and tipping the balance on another as is the concern with osteoporosis, heart disease, and cancer. We are focusing on the age-related changes that occur and the role they play in cancer. We're extremely concerned that many older women do not get much needed mammograms.

I would like to end by stressing our obligation to reach underserved populations. Breast cancer is a significant problem among black women and NCI has begun an initiative addressed to both young and older black women. Studies show a higher than expected breast cancer rate for young black women and lower survival rates for black women of all ages taken as a group. We are also pursuing relevant women's health research programs for Hispanic women and we are making expanded efforts to make certain activities culturally-relevant. Similar programs are underway for Native Americans, Alaskan Natives, and Native Hawaiians.

We need to continue our research, education, and communication efforts. We need to reach women from North Dakota to Louisiana, from Harlem in New York to Harlan County in Kentucky. It will take all of our skills, all of our drive to do this. We at NCI appreciate the concern of the Congress, the galvanizing courage of patient advocates such as those with us today.

Ms. **Oakar**. Dr. Lippman.

## STATEMENT OF MARC E. LIPPMAN, M.D.

Dr. **Lippman**. Thank you. I am extremely appreciative of the opportunity that you have provided, 1, to hold these hearings and; 2, to come before you and perhaps discuss some of the issues as I see them being.

I think that the idea of this Race for the Cure here in Washington is very exciting as a means of focusing a great deal of public attention. This past weekend I went to Sioux Falls, South Dakota, where they had a smaller, albeit equally enthusiastic Race for the Cure, also to support in that community work for breast cancer. I am rather proud of the fact I won my age group in the 10 kilometer race for that.

We have heard a lot of the statistics here. I do want to say that I feel a very personal sense of commitment on this issue—Nina Hyde, Rose Kushner, both who have been mentioned here several times today—extraordinary women—were both my patients. The wives of several men in this room are my patients now, as are several other women who have been present today; and in other more personal ways that I don't really wish to go into right now—this is truly a disease that has touched the lives of essentially every American.

It's an old adage that I was once told by a physician who trained me, that you never get a patient one at a time, and that's really true. It's one thing to talk immediately about the suffering of an individual woman with breast cancer, but the incalculable pain and enormous hardship that the entire family and friends of that person endures really can't be underestimated either.

In trying to deal with this issue, I'd like to say that I feel that I have some good news and some bad news. I think if you had asked me a decade ago, as someone who has devoted the last two decades of his professional life to treating and research concerning breast cancer, what causes breast cancer and what's going to cure it?

I would have responded more fundamental research: if you just kind of keep in there, keep supporting us, something will happen.

I don't believe that anymore. I think that the answers now are far more akin to the famous Manhattan Project that this country got behind several decades ago. I think that we rationally understand a great many of the specific issues that contribute not only to the cause of breast cancer but to its specific pathogenesis.

If you asked me to identify which exactly will be the one that cures breast cancer, I think it would be arrogant in the extreme for me to tell you that I know the answer.

If you asked me to say which of the next seven or eight specific avenues will lead to important changes in how we diagnose and treat patients, I could answer that question with great assuredness that I would be correct.

If you asked a caveman to stop a car, he might take out his club and start to beat on it, and eventually the car would stop, and that car would have no resale value. And in some sense, without trying to overstretch the analogy to surgery and radiotherapy, and chemotherapy, that's more or less the state-of-the-art.

On the other hand, I'm sure if I asked any of you to stop a car, even if you're not really inclined to know much about automobiles, in a couple of minutes you'd come up with several strategies—take out the gas, pull the distributor cap, turn off the ignition, take out the spark plugs. And when you think about it, all of those ideas come from a basic rational understanding of how a car works.

Furthermore, I would like to extend the very correct comments of Congressman Myers in saying that most human cancers that afflict grownups, not just breast cancer —lung, prostate, colorectal, pancreas, gastric—these epithelial cancers of human beings share much more in common than has up until recently been appreciated. And work that's done in breast cancer, almost beyond any question, has, and will continue to have major impact on these other diseases as well.

I think that there are a host of specific scientific avenues that we could go into. I ask your forbearance—I'd be happy to supply that in more detail, testimony for which there is not time today.

But suffice it to say that work on oncogenes, genes that specifically cause cancer; suppressor genes, genes that specifically stop cancer in its tracks—like brakes in a car—and other specific products of cancer cells that contribute to their unlimited growth and their nasty metastatic and malignant behavior, have been identified in animal models, and, in test tubes experiments, with human cancers, have been used in a curative way. I want to emphasize that.

Rationally designed experiments, based on knowledge that we already have about human malignancies has been successful in substantially changing the growth rate, and in some cases, curing human cancers in the test tube and in animal models.

What we're looking at now is a situation in which many of these projects are being stalled interminably or being brought with absolute crushing slowness to clinical reality because of an absence of sufficient funds for this kind of research.

I want to go on record as saying that the Cancer Institute itself has done a magnificent job. To bash the Cancer Institute would be like hitting the faucet in your sink because there was a drought and someone had emptied the reservoir.

We simply are looking at a situation in which appropriate funding, discreet amounts of money, amounts which are relatively minuscule compared with monies that are spent on many other issues that money is spent for, could dramatically, within the next half decade, alter the ways in which we are treating patients.

Ms. OAKAR. Would you repeat that? You're saying that if we gave appropriate funding—and, by the way, any of the panelists who want to submit additional testimony for the record, our record will be open for a week or two. We would be delighted to have whatever avenues you research or information you want to provide.

But, Doctor, I think that's a really significant statement you just made, and I'd like you to repeat that.

Dr. LIPPMAN. I'm happy to. It is my firm conviction that suitable levels of funding, based on research that is already under way and understandings that have already been achieved in the laboratory, suitable funding for this kind of research could dramatically alter the way we treat breast cancer in the next half decade.

Ms. **Oakar**. Within 5 years if we funded it properly.

Dr. **Lippman**. I could not agree more.

On the other hand, it's not simply the way it is often put that by funding more slowly you slow things down. Would that were the case. Unfortunately, that is far from the case. We are seeing—and there is ample evidence in the record to support this contention, that many of the most highly skilled individuals capable of performing such research are leaving the field because of their inability to be funded.

You have been told that 1 out of 6 approved grants is funded. The implication is that 1 out of 6 good grants gets the money it needs. Even that is a vast overestimation of the adequacy of funding.

Many people who are successful, as I have been in seeking grants, are informed in advance that they must put caps on the amount of money that they could even hope to get for their grants. Those grants are then often cut in ways that do not permit adequate performance of the research, and then there are mandatory down negotiations—10, 15, even 20 percent of the amounts of money that will be provided.

So that individuals who are even successful in seeking funding commonly find themselves, as soon as they reach the head of the line and they get their loaf of bread, instead of going off and eating it and doing the research, get things back on line again.

That is an unfortunate and extraordinarily realistic appraisal of how difficult it is for our best researchers in this country to carry on their business. They spend far too much of their time begging, borrowing, and attempting every effort to get hold of adequate funds to do their research instead of using the brains and the training that we hopefully provided them with to do their work.

So in summary, I am honored to have the chance to talk before you. The good news is truly, we have within our grasp the means of dramatically altering fundamentally our approach to breast cancer. The bad news is we're letting this slip through our fingers.

Ms. **Oakar**. Thank you very much.

[The prepared statement of Dr. Lippman follows:]

Marc E. Lippman, M.D.

Statement for the House Select Committee on Aging

Subcommittee on Health and Long-Term Care

May 16, 1990

I have been asked to give my thoughts about promising research for breast cancer and I am happy to provide this Committee with my views on the subject. Breast cancer is overwhelmingly the most common malignancy of women. 145,000 cases will be diagnosed this year and nearly 50,000 women will die of the disease. As female life expectancy increases, the number of cases will increase. Our understanding of factors that are responsible for the primary cause of the disease, its far higher degree of prevalence in North America versus other parts of the world is greatly enhanced and a variety of rationally designed biological approaches should rapidly be moved into clinical trials. We are faced with a situation in which carefully thought out and well verified ideas which could substantially improve the outcome of women with breast cancer are ready to be further tested and developed and the major limiting factor is financial resources. It is my firm belief that the availability of substantial funds at this time to support scholarly investigations in the areas of biology and causation, clinical trials, and prevention would all yield substantial benefits resulting in the savings of thousands of lives. In the next few paragraphs, I will enlarge upon these issues.

Recent developments in the past 5-10 years have revolutionized our technical skills in understanding the cellular and molecular biology of breast cancer. Molecules capable of converting normal breast epithelial cells to malignant cells have been identified and are likely to be pathogenetic for some human breast cancers. In addition, studies from other related malignancies have identified genes whose inactivation results in malignant behavior. These suppressor genes (analogous to the brakes on a car) are also very likely to be of significant importance in human breast cancer. The activity of these genes are expressed through cell proteins which are responsible for the malignant behavior of cancer cells. A variety of these proteins responsible for malignant behavior have been identified and characterized. Some are growth factors (proteins secreted by cells that induce either the cancer cells or surrounding cells to behave in abnormal ways) or cell surface molecules responsible for invasive and metastatic behavior. These latter two properties, invasion and metastases, are the two most lethal aspects of cancer. While undoubtedly other oncogenes, repressor genes, growth factors, and cell surface molecules responsible for metastatic behavior remain to be identified, *therapies directed at all these above mentioned sites have already shown their ability to inhibit and/or cure experimental models of human breast cancer in the test tube and in experimental animals.* All of these avenues need to be pursued, not consecutively, but simultaneously to bring them to clinical trial. In my opinion, it is virtually certain that some of these avenues will have substantial impact on the treatment of breast cancer.

Clinical trials of breast cancer are entering a new era even with information currently available. Autologous bone marrow transplantation, the use of recombinant molecules which can protect against the toxicity of chemotherapy, monoclonal antibody therapies used either by themselves or to target cytotoxic or other therapeutic molecules to cancer cells, new and rational approaches to antimetabolite therapy, and adoptive immunotherapy all could have a major impact on breast cancer. Clinical trials are fiendishly expensive and at the present time completely unsupported by third party payers. In order for the most innovative trials to be carried out, paer reviewed funding from federal sources is desperately needed.

Finally, efforts to prevent breast cancer could enter clinical trials with appropriate support. It is certain that 85% of breast cancer in North America is caused by environmental factors (obviously interacting with other genetic aspects of the disease). At least three different strategies are worthy of consideration in this regard and could result in very substantial reductions in breast cancer incidence. Large scale chemoprevention trials have a huge price tag, but the eventual benefit is incalculable.

I believe that funding through traditional competitive mechanisms aimed at supporting the most innovative biological, clinical, and preventive experiments in breast cancer not only could, but would substantially reduce the mortality rate from this disease within the decade.

I greatly appreciate the opportunity provided by this Committee to express my views on this subject.

Ms. **Oakar**. Dr. Henderson.

## STATEMENT OF MAUREEN HENDERSON, M.D.

Dr. **Henderson**. Thank you, Madam Chairman.

My message is that we can now, at this point in time, do research to find ways of preventing breast cancer, but there are neither the funds nor according to the director of NCI, the mechanisms—the funding mechanisms to get that research on the road.

The highly competitive funding conditions that you have been hearing about, in which only the top 25 percent of all approved research projects are funded are particularly hard on low technology and long-term research, such as prevention research and nutrition research. And nutrition research—research in ways of presenting cancer by changing nutrition—is suffering disproportionately at a time when the National Cancer Institute estimates that as much as 35 percent of all cancers could be prevented by the right changes in diet.

Research to find the right changes in diet is more important, in my opinion, in breast cancer than any other cancer at the present time because of the rapidly rising rate of new cancers, new breast cancers, in older American women.

Women between the ages of 65 and 74 had an increase of 40 percent in their annual rates of new cases of breast cancer during the last 12 years, for which we have total counts. And women aged 75 to 84 had a 30 percent increase in annual cases of breast cancer during that same period. In the aggregate, this measure had led to women over 50 having 10 times the risk of breast cancer as women between the ages of 18 and 50.

We have absolutely no explanation for the continuing increase in older women. Current changes in the age at which women have their first pregnancy and in their uses of mammography do not explain that escalation in older women.

As we've heard, and I agree, systematic mammography screening can be of immense help to women because it detects cancers at a very early stage but mammography can't do anything towards preventing breast cancer. Research on mammography does not substitute for research on prevention. We need both. And it happens that both of those areas of research—prevention and early diagnosis—are at the end of the research spectrum that is most hurt; hurt disproportionately by the constrained funding that has been in existence for the last 10 to 15 years.

And in fact, as an example, we allowed 15 years to elapse before we followed up our first findings that screening mammography could save lives, with current research efforts to find the best technology and the best systematic uses of mammography that can make sure that every breast cancer victim benefits from the advantages it can give.

Research on ways of preventing healthy women from getting breast cancer are virtually nonexistent, although almost 10 years have gone by since the National Cancer Advisory Board, with Rose Kushner as a member, agreed that it was a priority to carry out a prevention trial to see whether a change in diet would prevent breast cancer. Ten years have gone by since then and we still have not found the right funding source nor the right funding mechanism to get that research started.

We knew 10 years ago that countries with high average fat consumption had high rates of breast cancer, and countries with low average fat consumption had low rates. And we've learned that the average circulating levels of reproductive hormones are lower in countries with lower rates of breast cancer.

More than 2,000 women in Seattle, Houston, and Cincinnati helped us to learn that if you lower the fat in the diet, you lower the circulating levels of reproductive hormones.

We have had an increase in the number of observational animal studies linking dietary fat with colon, prostate, ovarian, as well as breast cancers. But we haven't had one preventive study—one preventive trial—looking at the diet-related cancers in either men or women.

Now, we have, however, enough faith in the hypothesis that fat is linked to breast cancer and the other reproductive cancers that we've made national recommendations to lower the fat in the diet to reduce the risk of those cancers.

Unfortunately, the public has not heard those recommendations. During the last 30 years, the average consumption of fat in this country has increased by 20 percent. Most of that increase is of vegetable fat—polyunsaturated fats. And very unfortunately, the statistical analysis of the variations in breast cancer rates in the different countries of the world, and analysis of the increasing trends in breast cancer rates in this country and in Japan show that vegetable fats are no safer than animal fats as far as breast cancer and the other reproductive cancers are concerned.

Now, where does that leave us? Do women have to choose between heart disease and breast cancer ? They don't.

We need to tell them which overall change in diet they should adopt, and their daughters should adopt, so they can lower their risk of both breast cancer and heart disease.

And this study, a study to give them that answer can be done. Those 2,000 volunteers in Cincinnati, Houston, and Seattle proved that American women are willing to make major changes in their diet and to maintain those changes if it will protect their health.

A study that would provide that answer in 10 years has been designed and has been approved as meritorious by peer reviewers.

The National Cancer Institute, as you've heard Dr. Broder say, believes that an answer of that kind should be obtained and has high priority.

There is, as I said before, no identifiable source of funds and no mechanism for funding a long-term prevention trial of this kind.

As a scientist, I believe that research to see whether changing our diet prevents breast cancer is a public health priority. As an older woman, I am totally frustrated that the evidence is believed to be strong enough to make recommendations to the public to change their diet, but the issue isn't important enough to spend money on doing research to see if those recommendations are correct.

Madam Chairman, we need your help and the help of your colleagues to get funds to carry out this research and to make sure that women get the answer about how to avoid these diseases in this century and not in the next century.

Thank you.

[The prepared statement of Dr. Henderson follows:]

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Cancer Prevention Research Program

Testimony to the
Subcommittee on Health and Long Term Care
by Maureen M. Henderson, M.D.
Head, Cancer Prevention Research Program
May 16, 1990

- The problems faced in getting funds for breast cancer research reflect the imbalance between the overall cancer research budget and the amount of meritorious research that could be done today as well as the imbalance between funds allocated to research on prevention of cancer versus those allocated to basic science and clinical cancer research.

- Although Congress has been sympathetic to the National Cancer Institute, its budget has only been increased by 23 million in inflation adjusted dollars during the last decade. Its ten year percentage increase is the lowest among all the National Institutes of Health.

- Highly competitive conditions in which only the top 25 percent of scientifically approved research projects are funded are particularly hard on low technology, high risk research such as prevention and nutrition, and nutrition prevention research is suffering disproportionately at a time when the NCI estimates that over 35 percent of all cancers could be prevented by the right changes in diet.

- Research to find the right changes in diet is of highest priority in prevention of breast cancer because of the rapidly rising annual rate of new cases of breast cancer among older women.

- Women aged 65-74 years have had a 40 percent increase in their annual rates of new cases of breast cancer and women aged 75-84 have had a 30 percent increase in the 12-years from 1974 to 1986. As a result, women over 50 collectively have ten times the breast cancer risk of women under 50 (327 versus 32 per 100,000). We have no explanation for this increasing breast cancer risk of older women. Current changes in age at first pregnancy and use of mammography to detect otherwise hidden cancers do not account for the escalation.

- Systematic mammography screening can be of immense help to women because it detects cancers at a very early stage but mammography cannot do anything towards preventing breast cancer. Research on mammography does not substitute for research on prevention. It is a close but different segment of the entire spectrum of breast cancer research.

- Both prevention and early detection, however, are at the end of the research spectrum that has suffered disproportionately from a decade of constrained budgets. Because of these constraints, we have allowed 15 years to go by before following up our first evidence that screening mammography can save lives with research efforts to identify the best technology and the best systematic uses of mammography to help a majority of breast cancer victims reap its benefits.

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- Research on ways of preventing healthy women from ever getting breast cancer is virtually nonexistent, although it is almost ten years since the National Cancer Advisory Board stated that a trial to see if a high quality low fat diet would prevent breast cancer was a research priority.

- We knew ten years ago that high fat national diets are associated with high rates of breast cancer and that national increases in fat consumption are followed by increases in national rates of breast cancer. Since then we have learned that women who move from countries with low rates of breast cancer to Australia acquire high Australian rates within 15 to 20 years of residence.

- Two-thousand (2,000) healthy women in Seattle, Houston, and Cincinnati have also helped us to learn that circulating levels of reproductive hormones are lowered by reducing dietary fat and we know that the average levels of reproductive hormones are lower in countries with low rates of breast cancer.

- The variety of observational and animal studies that have specifically linked dietary fat to high rates of breast cancer as well as cancers of the colon, rectum, ovary, uterus and prostate have steadily increased. But there have been no dietary prevention studies of fat related cancers in women or men even though the hypothesis has been taken seriously enough to make national recommendations to reduce fat in the diet as a means of preventing prominent cancers.

- In spite of these recommendations, per capita national fat consumption of fat increased about 20 percent over the past 30 years--almost all the increase being the consumption of polyunsaturated fat.

- Unfortunately the statistical analyses of international human experience and of historical events in this country and Japan show that vegetable fats as a group are no safer than animal fats when it comes to cancers of the breast and other reproductive organs.

- Women need to know which one overall change in dietary lifestyle they and their daughters can adopt that will prevent both breast cancer and heart disease.

- Such a study can be done today. Those 2,000 volunteers in Seattle, Houston and Cincinnati proved that American women are willing to test major dietary changes that may protect their health and that they can maintain those changes over many years.

- A multidisciplinary group of scientists from twelve different parts of this country designed a study to get the answer in ten years. The study was rated scientifically meritorious by a blue ribbon group of peer reviewers, and the administration of the NCI says it gives high priority to getting the answer this trial could provide. There is however no source of funds for this research. We need your help in getting support for a prevention trial that will get a definite answer for American women in this and not the next century.

- Chairman Roybal, you have the opportunity to address both the gap between the research that can be done and the research we can fund, as well as the imbalance between cancer prevention and other fields of cancer research. I urge you to work with the Labor and Health and Human Services Appropriations Subcommittee to ensure that new funds accompanied by report language are provided to the Cancer Prevention and Control Research arm of the National Cancer Institute to pursue this research that is crucial for all.

FRED
HUTCHINSON
CANCER
RESEARCH
CENTER

## An Important Public Health Problem

- About one in eleven women in the United States will ultimately develop breast cancer, and about half of these will die of their disease. An estimated 142,000 new breast cancer cases occurred in 1989 as well as an estimated 132,000 new cases of cancer of the colon, rectum, ovary or uterus (endometrium).
- Increasing rates of new breast cancers, particularly among post-menopausal women, have precluded any reduction in breast cancer death rates over the past 20-30 years.
- Cardiovascular disease causes more deaths in women than men, and women account for 58 percent of the health care expenditure for cardiovascular disease, estimated at $56.8 billion in 1985.
- A variety of types of studies have specifically linked dietary fat to the high rates of cancers of the breast, colon, rectum, ovary and uterus, and to the high rate of coronary heart disease among women in America and Western Europe. Almost all studies of coronary heart disease prevention have been conducted in men. There have been no dietary prevention studies of fat related cancers in men or women, although recommendations have been made to reduce fat in the diet as a means of preventing prominent cancers and coronary heart disease. In spite of these recommendations, the per capita fat "disappearance" in the United States has increased by about 20% over the past 30 years. Almost all of this increase has been in the form of polyunsaturated fat.
- There has been preliminary work toward a low-fat intervention trial, our investigative group has worked for several years to develop and evaluate a dietary intervention program; to synthesize available information pertinent to the hypotheses to be tested; and to develop a research plan to determine the ability of this "healthy diet" intervention program to prevent prominent cancers and cardiovascular diseases.
- Over 2,000 women in Cincinnati, Houston and Seattle have been randomly assigned to either our dietary intervention program or to a comparison group and have been followed for as long as three years or more. This work establishes the acceptability of our study plan to American women, the feasibility of recruiting women in sufficient numbers, and the ability of the dietary intervention program to achieve dietary goals. Observed reductions in blood cholesterol and blood hormones have yielded insights into the mechanisms

whereby a low-fat diet may reduce the risks of heart disease and certain cancers. These studies have been sponsored by the National Cancer Institute.

- During 1988 a multi-disciplinary team with outstanding experience and expertise in medicine, nutrition, psychology, behavioral sciences, oncology, epidemiology, and biostatistics was assembled to conduct the Dietary Fat Intervention Trial for Disease Prevention in Women, or more briefly the DIET FIT Trial.
- The proposed trial would randomly assign 24,000 women, aged 55-69 and currently consuming a diet high in fat, to either the "healthy diet" intervention program or to a comparison group. Approximately 2,000 women would be enrolled at clinics located in Baltimore MD, Cincinnati OH, Sacramento CA, Houston TX, Iowa City IA, Los Angeles CA, Oakland CA, Pittsburgh PA, Portland OR, Seattle WA, Vancouver BC, and Winston-Salem NC.
- Women assigned to the intervention group would be taught to reduce the fat content of their diets from about 40% of calories to about 20% of calories, and to maintain their reduced level throughout the duration of the trial. The intervention has been demonstrated to be effective during our two year pilot study, with study subjects able to maintain an average of 23% calories from fat or less, over this period. This makes our intervention program the most effective dietary intervention every developed. Women assigned to the comparison group will continue to follow the dietary habits of their choice.
- The study offers, during the 10 year follow-up, excellent opportunities to learn more about the mechanisms of disease development in women, in addition to providing statistically powerful tests of the ability of the intervention food plan to prevent caner of the breast, colon, rectum, ovary and endometrium, which together account for over half of the total cancer occurrence among women in this age range, and to prevent coronary heart disease.
- The DIET FIT proposal was reviewed by a large team of independent scientists with expertise in both cancer and coronary heart disease, under the auspices of the National Institutes of Health on July 20-21, 1989.
- This distinguished group recommended approval of the DIET FIT grant request with very high priority, and summarized their 58 page report as follows: "The Special Review group believes this project is timely and important..." and "They further believe the results will be highly significant whether convincingly

positive or negative outcome is observed. The DIET FIT provides as good an opportunity as possible to evaluate fat versus chronic diseases in the foreseeable future..."

- The leadership of the National Cancer Institute (NCI) included DIET FIT in the list of grants to be funded in September 1989.
- As the final step in the funding decision the NCI's board of outside scientists and lay persons, know as the National Cancer Advisory Board (NCAB), were asked to concur in the funding recommendation. In closed sessions on September 18, 1989 and December 5, 1989 the NCAB singled out the DIET FIT proposal and ultimately recommended against funding. In a letter to NCI Director Samuel Broder, dated December 11, 1989, the NCAB Chairman explained that their negative recommendation, which we believe to be without precedent, was on a basis "other than scientific or technical merit". He elaborated that they judged it to be inappropriate "to fund a trial of this magnitude as an RO1 grant from the research project grant pool". This is the pool available to competitively fund proposals initiated by investigators outside the National Institutes of Health.
- Even though this important study has received a strong scientific endorsement and a priority score within the fundable range, the leadership of the National Cancer Institute must abide by the NCAB recommendation and cannot fund this proposal. Since the NCI was designated the lead institution in the DIET FIT reviews the National Heart, Lung, and Blood Institute is similarly prevented from cost sharing. Hence the NIH does not intend to fund this proposal. There is no mechanism for appeal by the investigators.

## Increases in Breast Cancer Incidence Rate Between 1974 and 1986

| Age at Diagnosis | Percentage Increase |
|---|---|
| 25-44 | 15 |
| 45-54 | 6 |
| 55-64 | 20 |
| 65-74 | 40 |
| 75-84 | 30 |
| Total | 28 |

**Nine Standard SEER Registries. Females Only, All Races, by Five-Year Age Groups**

### Breast Cancer Incidence, 1974-1986

### Nine Standard SEER Registries. Females Only, All Races, by Five-Year Age Groups

| | Year of Diagnosis | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age | 1974 Rate | 1975 Rate | 1976 Rate | 1977 Rate | 1978 Rate | 1979 Rate | 1980 Rate | 1981 Rate | 1982 Rate | 1983 Rate | 1984 Rate | 1985 Rate | 1986 Rate |
| Total | 99 | 92 | 89 | 89 | 89 | 91 | 92 | 96 | 97 | 102 | 106 | 114 | 117 |
| 10-14 | | | | | | | 0 | | | | | | |
| 15-19 | | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | | 0 | 0 | |
| 20-24 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 | 1 | 2 | 1 | 1 | 1 |
| 25-29 | 8 | 9 | 9 | 8 | 9 | 8 | 8 | 8 | 9 | 9 | 9 | 7 | 7 |
| 30-34 | 29 | 25 | 23 | 28 | 24 | 27 | 26 | 28 | 31 | 27 | 25 | 27 | 30 |
| 35-39 | 66 | 55 | 56 | 58 | 61 | 54 | 62 | 65 | 63 | 63 | 71 | 68 | 65 |
| 40-44 | 119 | 115 | 104 | 104 | 111 | 104 | 107 | 105 | 107 | 115 | 122 | 124 | 131 |
| 45-49 | 196 | 178 | 184 | 170 | 158 | 163 | 150 | 159 | 171 | 161 | 168 | 189 | 186 |
| 50-54 | 213 | 208 | 199 | 192 | 191 | 188 | 181 | 186 | 179 | 191 | 201 | 219 | 217 |
| 55-59 | 257 | 231 | 222 | 220 | 212 | 212 | 215 | 235 | 225 | 253 | 247 | 267 | 263 |
| 60-64 | 278 | 261 | 246 | 251 | 261 | 268 | 259 | 271 | 281 | 287 | 300 | 324 | 331 |
| 65-69 | 318 | 292 | 282 | 267 | 276 | 296 | 299 | 306 | 307 | 332 | 349 | 367 | 402 |
| 70-74 | 326 | 297 | 314 | 283 | 298 | 322 | 338 | 333 | 342 | 356 | 381 | 403 | 424 |
| 75-79 | 369 | 354 | 307 | 322 | 331 | 335 | 343 | 358 | 353 | 368 | 410 | 413 | 450 |
| 80-84 | 365 | 342 | 342 | 361 | 323 | 342 | 349 | 381 | 375 | 398 | 380 | 459 | 443 |
| 85+ | 383 | 357 | 374 | 401 | 384 | 386 | 367 | 408 | 362 | 385 | 389 | 414 | 391 |

Ms. **Oakar**. Thank you very much, Doctor.

I just wanted to say that apparently there was an article about you and your efforts relative to research in diet and breast cancer in Ms. magazine. And the National Women's Health Network Diet and Cancer organization are saying the National Women's Health Network, a nonprofit women's health advocacy group, received so many letters relative to that article that they brought a few of them here today. There are hundreds of letters from women, wondering why you can't get the funding you need to do important research.

Again, I want to emphasize what Dr. Lippman is saying, and that is, we're not dumping on Dr. Broder today, but we are saying that something's wrong in our value system at this place, in my judgment. You should know that these letters relate to the kind of study that you want to do; because we're not finished, are we?

We hear all this stuff about fiber and so on. I have a number of grants that were not funded that relate to diet, including alcohol consumption and the fat intervention trials that weren't funded, apparently you were trying to get, and so on. So there's an awful lot of work to be done. You ought to know that this mail is in response in part to what is your frustration.

The women of this country are behind you and now we've just got to get everybody else behind you.

Thank you.

[The brochure follows:]

# THE DIET YOUR DOCTOR WON'T GIVE YOU

Prepared for **Ms.** Magazine
by the National
Women's Health Network

Fat, schmaltz, grease—call it what you will: it currently has a bad name among doctors and dieticians. You'll find it mainly in meats, dairy products, and vegetable oils—and often in surprising quantities. Peanuts, for example, are 50 percent fat. It can clog arteries, contribute to obesity, and may lead to heart disease, diabetes, and a variety of cancers. In particular, scientific research over the past 20 years suggests a strong link between fat in our diet and breast cancer. Since 1 in 10 women will get breast cancer, it is of the utmost importance that we have information that may help reduce risk of this disease.* How much fat is too much? Many groups are recommending a 30 percent fat level, but we agree with those scientists whose research shows that keeping fat intake down to 20 percent of your total calories is the most protective approach.

The good news about the 20 percent goal is that it is "doable." New research suggests that with the proper motivation and adequate information, women can bring down their fat intake to 20 percent of calories and keep it there without difficulty. An added benefit: many women lose weight just by following a diet that has less fat.

This brochure provides the nuts-and-bolts information you will need to help you embark on a 20 percent low-fat eating plan. But keep in mind that fat isn't the only dietary culprit. As you cut back on fat, also watch sugar, salt, and alcohol. And give yourself plenty of variety, eating from all the groups in our rich and diverse food basket.

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*For an analysis of the scientific research that links breast cancer to dietary fat, see "Breast Cancer Prevention: A Controversial New Program," by Susan Rennie, Ms. Magazine, April, 1987.

## FOOL 'EM FOODS

**Baked corn tortilla chips**
**Smoothies made with frozen fruit, skim milk, and low-fat yogurt**
**Breakfast on a muffin (see Recipes)**
**Fruit-juice Popsicles**
**Curried chicken made with a low-fat yogurt base**

## LOW–FAT SNACKS

**Veggie pita sandwich moistened with yogurt sauce**
**Baked apple with cinnamon and one tablespoon maple syrup**
**Any fruit or vegetable (except avocado)**
**Air-popped popcorn**

## FIGURING OUT YOUR FAT ALLOWANCE

A simple and accurate way of measuring your calorie intake is to keep a five-day DIET DIARY. Write down everything you eat and drink, *starting with the previous two days* (this is so that you will not subconsciously modify your eating habits as you record them). Use a calorie counter to find the number of calories in each food or drink.

**STEP ONE: How many calories do you eat in a day?**
Before you can calculate your fat allowance you need to know how many calories you average per day. Women 18 to 40 should average 1,600 to 2,000 calories per day, depending on your age within this range and how active you are. Women over 40 should average 1,400 to 1,600 calories per day, depending on age and activity.

1. ______________

**STEP TWO: How much fat do you eat daily?**
Since most Americans have a daily fat intake of 40 percent of total calories, *multiply your daily calories by 0.4.* (Of course, you can precisely measure your fat intake if you use a reference such as THE LIFESAVER FAT AND CALORIE GUIDE poster [see Resources] and keep a separate record of your fat intake when you do the diet diary.)

2. ______________

**STEP THREE: How much fat should you eat daily?**
To calculate the desired 20 percent fat level, multiply your daily calorie intake (Step One) by 0.2.

3. ______________

**STEP FOUR: What is your daily fat allowance in grams?**
Divide your daily fat calorie allowance by 9 (the number of calories per gram of fat).

4. ______________

Your answer to Step Four equals your daily fat allowance in grams. (This is necessary since most food labels list fat in grams.)

## EXAMPLE

**1. Your diet per day consists of 2,000 calories**
**2. 2,000 calories x 0.4 (40% fat) = 800 fat calories per day**
**3. 2,000 calories x 0.2 (20% fat) = 400 fat calories per day**
**4. 400 fat calories ÷ by 9 = 44.4 grams fat daily**

| AVOID THIS | fat (g) | am't/ size | CHOOSE THIS | fat (g) | am't/ size |
|---|---|---|---|---|---|
| Croissant | 6 | 1 (1 oz) | English muffin | 1 | 1 |
| Ritz cracker (Nabisco) | 8 | 9 (1 oz) | Golden Rye Crispbread (Wasa) | 0 | 3 (1 oz) |
| Whole milk yogurt | 5 | 1 cup | Low-fat yogurt | 2-3 | 1 cup |
| Natural cereal (Quaker) | 7 | 1 oz | Corn Flakes (Kellogg's) | 0 | 1 oz |
| Oreos | 7 | 3 (1 oz) | Ginger snaps | 3 | 4 (1 oz) |
| Cream of mushroom soup (Campbell) | 11 | 10 oz | Tomato soup (Campbell) | 6 | 10 oz |
| Tuna (lt., in oil) | 10 | 3 oz | Tuna (lt., in water) | 1 | 3 oz |
| Ground chuck | 13 | 3 oz | Turkey, no skin | 4 | 4 oz |
| Potato chips (salted) | 10 | 1 oz | Pretzels (high sodium) | 1 | 1 oz |

## 3-DAY MENUS

Realistically, everyone will want to have a "blowout" now and then. There's nothing wrong with eating an occasional Fettuccine Alfredo plus zabaglione. But, along with that splurge should come a trade-off in fat intake from other meals, or in other items from the meal. During the big treat week cut back even further on foods with fats in order to balance out those treats.

With this approach, you can work in a regular weekly splurge day with little difficulty. The following sets of menus at a 20 percent fat level show a 2,000 calorie diet (typical for women 18 to 40) and a 1,500 calorie diet geared to women 40 and over.

**TABLE I**

**2,000 CALORIE DIET (Maximum Fat Calories = 400 = 43 grams)**

|  | FAT INTAKE | Fat Grams | Fat Cals | Total Cals |  | Fat Grams | Fat Cals | Total Cals |  | Fat Grams | Fat Cals | Total Cals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BREAKFAST | 2% Raspberry yogurt | 4 | 36 | 260 | Heated turkey and cheese (1 oz. each) on English muffin | 8 | 72 | 250 | Bran cereal | 0 | 0 | 90 |
|  | Toast (2 slices) | 1 | 9 | 140 |  |  |  |  | Skim milk | 0 | 0 | 90 |
|  | Orange juice | 0 | 0 | 110 |  |  |  |  | Grapefruit | 0 | 0 | 110 |
|  |  |  |  |  |  |  |  |  | Orange juice | 0 | 0 | 110 |
| LUNCH | Tuna pita sandwich w/1 T. mayo | 12.4 | 111.6 | 270 | Clam/Corn chowder (1% milk) | 2.5 | 22.5 | 135 | Marinated pasta w/1 T. low-fat dressing | .8 | 7.2 | 182 |
|  | Carrot sticks | 0 | 0 | 60 | Bacon (3 slices), lettuce, tomato sandwich | 11.4 | 102.6 | 360 | 2% Cottage cheese | 2 | 18 | 90 |
|  | Broccoli w/1 T. low-fat dressing | 1.8 | 7.2 | 43 |  |  |  |  | Apple | 0 | 0 | 90 |
| DINNER | Spaghetti w/meatballs and tomato sauce | 34.4 | 219.6 | 720 | Broiled Chicken* w/herbs and wine | 12.2 | 110 | 251 | Sirloin steak* | 36 | 324 | 439 |
|  | Italian bread w/pat butter | 2.7 | 24.3 | 70 | Rice w/mushrooms | .9 | 8.1 | 200 | Baked potato, plain | 0 | 0 | 100 |
|  | Salad w/1 T. low-fat dressing | .8 | 7.2 | 165 | Fresh steamed broccoli, no butter | 0 | 0 | 35 | Salad w/1 T. low-fat dressing | .8 | 7.2 | 165 |
|  |  |  |  |  |  |  |  |  | Fruit and wine | 0 | 0 | 190 |
|  | TOTALS | 46.1 | 412.2 | 1838 |  | 35.0 | 315.2 | 1231 |  | 39.6 | 356.4 | 1656 |

*4 oz. serving

## GOOD FAT?

All fats are not equal. Researchers are trying to find out which fats, in what proportions, may be less harmful than others.

There is increasing evidence now to suggest that fish oils reduce the incidence of heart disease as well as malignant breast tumors in experimental animals. This does not mean that we should jump into massive fish eating, but we should be sure to add foods rich in these so-called omega-3 oils to our diets.

Olive oil, a monounsaturated fat, has been shown in recent studies to decrease "bad" cholesterol (LDL) in the blood, and it may also maintain the levels of "good" cholesterol (HDL). Population studies have shown that the low levels of breast cancer in Greek and Spanish women may be linked with the high proportion of olive oil in their diets. And laboratory tests indicate that animals fed diets rich in olive oil develop fewer breast tumors than animals on high safflower and corn oil diets.

Dr. Leonard Cohen, a nutrition and cancer research specialist at the American Health Foundation in New York, believes that although we don't yet have the full picture on olive oil, as we cut back on our total fat, more of the fat we eat should be olive oil. (But, he cautions, eating too much of any kind of fat is ill advised.)

**1. Eat more fish—especially more salmon, mackerel, sardines, and fresh tuna, rich in omega-3 oils.**

**2. Use olive oil instead of other vegetable oils for cooking and salad dressings—but use all oils sparingly.**

**TABLE II**
**1,500 CALORIE DIET (Maximum Fat Calories = 300 = 32 grams)**

| | FAT INTAKE | Fat Grams | Fat Cals | Total Cals |
|---|---|---|---|---|
| BREAKFAST | Fruit Smoothie made w/low-fat yogurt and skim milk | 1.9 | 17.1 | 240 |
| | Bran muffin | 4 | 36 | 120 |
| LUNCH | Hamburger sandwich (meat, 3.6 oz.) | 9.8 | 88 | 255 |
| | 2% Cottage cheese | 2 | 18 | 90 |
| | Carrot sticks | 0 | 0 | 60 |
| DINNER | Broiled salmon* | 9 | 80 | 230 |
| | w/pat butter | 2.3 | 20.7 | 21 |
| | Baked potato w/pat butter | 2.3 | 20.7 | 121 |
| | Fresh spinach w/mushrooms | 1 | 9 | 100 |
| | TOTALS | 23.3 | 289.5 | 1237 |

| | Fat Grams | Fat Cals | Total Cals |
|---|---|---|---|
| Raisin Bran cereal w/1% low-fat milk, | 3.5 | 31.5 | 192 |
| Cantaloupe or banana | 0 | 0 | 110 |
| Tomato soup | 6 | 54 | 160 |
| Wheat Thins (4) | 2 | 18 | 128 |
| Apple | 0 | 0 | 90 |
| Baked breaded veal | 14.4 | 130 | 280 |
| schnitzel* w/ 2 pats butter | 4.6 | 41.4 | 42 |
| Salad w/low-fat Italian dressing | .8 | 7.2 | 165 |
| Vegetarian baked beans | 2 | 18 | 210 |
| | 33.3 | 300.1 | 1377 |

| | Fat Grams | Fat Cals | Total Cals |
|---|---|---|---|
| Juice | 0 | 0 | 110 |
| Cream of Wheat | 0 | 0 | 100 |
| Toast (1 slice) | 0 | 0 | 70 |
| w/pat butter | 2.3 | 20.7 | 21 |
| Turkey sandwich w/lettuce, tomato, on Kaiser roll w/mustard and mayo (1½ T.), | 11.9 | 107.1 | 437 |
| Coleslaw | 4.4 | 40 | 60 |
| Linguine w/stir-fried vegetables | 8 | 72 | 300 |
| Italian bread(2 slices) w/pat butter | 2.3 | 20.7 | 140 |
| Fruit | 0 | 0 | 120 |
| | 28.9 | 260.5 | 1358 |

*4 oz. serving

# RECIPES*

### BREAKFAST ON A MUFFIN

**1 whole wheat English muffin, split**
**1 slice lean ham or turkey ham (1 ounce)**
**1 slice part-skim mozzarella cheese (1 ounce)**

Preheat broiler. Top one muffin half with ham, the other with cheese, broil until ham is hot and cheese is melted. Put them together, wrap in foil, and rush out the door. (Remember to turn off the broiler!)

Makes 1. 250 CALORIES, 8 GRAMS FAT.

### SPLIT PEA VEGETABLE SOUP

**1 cup dried split peas**
**2 cups water**
**½ onion, chopped**
**6-8 sprigs parsley, chopped**
**2 carrots, cut in rounds**
**2 stalks celery, chopped**
**2 tablespoons tomato sauce**
**2 bouillon cubes**
**6-7 cups water**
**¼ cup cabbage, chopped**
**¾ cup rice, uncooked**
**2 tablespoons Parmesan cheese to garnish**

Cook split peas in 2 cups water until soft. Brown onions lightly in non-stick skillet, add parsley and cook a few minutes. Add to cooked split peas, along with rest of ingredients except rice and cheese. Cook about 1 hour. Add rice and cook about 20 minutes (40 if brown rice is used), stirring frequently. If soup gets too thick, add more water or broth. Garnish with Parmesan cheese.

Serves 6-8. PER SERVING (6): 200 CALORIES, ½ GRAM FAT.

### CHINESE CHICKEN SALAD

**1 whole chicken breast, skinned and poached**
**1-2 cups cooked barley**
**2 tablespoons low-fat Italian dressing**
**1 cup fresh or canned bean sprouts**
**½ cup chopped celery**
**½ cup chopped green onion**
**2 teaspoons soy sauce**
**1 tablespoon lemon juice**
**1 tablespoon low-fat mayonnaise**
**1 tablespoon plain low-fat yogurt**
**1-2 cups cooked fresh tomatoes (optional)**

Poach chicken breast in 2 cups of water lightly seasoned with dill, onion powder (or chopped onion), and salt. Bring water to a boil, add chicken, cover, reduce heat and simmer for 30 minutes, or until chicken is no longer pink inside. Remove from liquid and let cool. (Save the broth for soup.)

Meanwhile, cook barley following package directions (takes about 45 minutes). When barley is tender, remove from heat, drain off any excess liquid and toss with Italian dressing while it's still warm.

Cut cooled chicken into ½ inch cubes and add to barley, along with bean sprouts, celery, and green onion. In a separate bowl, combine soy sauce, lemon juice, mayonnaise, and yogurt. Pour over chicken and vegetables and mix well.

If desired, sprinkle about ¼ cup chopped fresh tomatoes on top of each serving for added color.

Makes about 5 cups. PER CUP: 135 CALORIES, 3 GRAMS FAT.

### HEARTY MEATLOAF

**1 pound extra lean ground beef**
**¾ cup oatmeal**
**1 small onion, finely diced**
**1 stalk celery, finely diced**
**1 carrot, finely grated**
**½ cup plain low-fat yogurt**
**2 tablespoons fresh parsley, chopped**
**2 tablespoons chili sauce**
**½ teaspoon EACH thyme and oregano**
**¼ teaspoon pepper**

**Tomato Glaze:**
**½ cup tomato sauce**
**1 tablespoon Dijon mustard**
**1 tablespoon brown sugar**
**¼ teaspoon nutmeg**

Combine all ingredients for meatloaf, mix well and mound in metal pie tin. (If making ahead, stop at this point, wrap well and refrigerate.) When ready to bake, mix together Tomato Glaze and pour over meatloaf. Bake in 350 degree oven for 45-55 minutes.

Serves 4-6. PER SERVING (4): 375 CALORIES, 10 GRAMS FAT.

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*** from *Lowfat Lifeline*, see Resources**

# RESOURCES

## *POSTERS AND NEWSLETTERS*

### THE LIFESAVER FAT AND CALORIE GUIDE

This 18" by 24" poster gives at-a-glance information on the fat content of more than 200 common foods. It also flags high-sodium foods, gives cholesterol content, and tells how to calculate your fat allowance.
($3.95 standard, $7.95 laminated, from Center for Science in the Public Interest, CSPI, 1501 16th Street, N.W. Washington, D.C. 20036.)

### NUTRITION ACTION

This health newsletter provides a wealth of carefully researched consumer information and has pioneered in reporting dietary-fat health issues, especially in articles by nutritionist Bonnie Liebman.
(10 issues per year for $19.95, with membership; from CSPI.)

### THE FELIX LETTER

A small independent health newsletter published by Berkeley nutritionist Clara Felix that specializes in information relating to fats and oils.
(6 issues per year for $6. Sample issue plus index, from P.O. Box 7094, Berkeley, CA 94707.)

## *BOOKS*

### THE FAST-FOOD GUIDE
**by Michael Jacobson and Sarah Fritschner**

Provides fascinating nutritional information on the content and nutritional value of fast foods. Includes a chain-by-chain (from Arby's to Wendy's) breakdown of calories, fat, etc., in each of the foods sold.
($4.95 from CSPI)

### DIET, NUTRITION, AND CANCER

Written by the National Academy of Sciences' Committee on Diet, Nutrition, and Cancer, this large book explains how NAS arrives at its conclusion that high-fat diets contribute to heart disease, as well as to breast, colon, and prostate cancers.
($19.95 from the National Academy Press, 2101 Constitution Ave., N.W. Washington, D.C. 20418.)

## *LOW-FAT RECIPES*

### LOWFAT LIFELINE

A monthly newsletter packed with nutritious, delicious, creative low-fat recipes.

($15 for 12 months from LOWFAT LIFELINE, 52 Condolea Court, Lake Oswego, OR 97034. Also available from the same address: *The Lowfat Lifestyle*, by Valerie Parker and Ronda Gates, $10.95, a compendium of tips, recipes, and exercises.)

### THE PASTAHHH NEWSLETTER

Recipes published quarterly by the National Pasta Association, P.O. Box 25496, Washington, D.C. 20007.

### THE EGG LOVER'S HEART HEALTHY COOKBOOK

Free with long SASE from the Egg Nutrition Center, 2501 M Street N.W., Suite 410, Washington, D.C. 20037.

Authors: Susan Rennie, Ph.D. (Chair, NWHN Breast Cancer Project); Jan Stallmeyer, R.N. (Chair, NWHN Board of Directors); Tracey Orloff, M.P.H. (NWHN Program Director).

For more information on women's health issues, write to the National Women's Health Network, 1325 G Street, N.W., Washington, D.C. 20005.

ILLUSTRATIONS BY ANTHONY RUSSO

**Ms. Oakar.** Our next witness is Mr. Kushner. Harvey Kushner, I think Rose would be very proud of you—you don't need me to say that. But the fact is that in my private conversations with her over the years, one of the things that pleased her so much was your support for the fact that she spent so much time on this issue with so many women across the country that sometimes she wasn't able to have the kind of time with her family that she would have liked to have had, and you were always very supportive.

So the fact that you are here today to attempt to bring her message and your message to this Congress is very important to those of us who knew Rose, and very, very important to, I think, her memory, and obviously her legacy lives on. So we are happy to have you here.

**Mrs. Morella.** Madam Chairman, will you yield?

**Ms. Oakar.** Yes, I'd like to yield to my colleague.

**Mrs. Morella.** I'd just like to add a note of welcome to the entire panel, but especially to Harvey Kushner, who has carried on that kind of commitment and tradition in addition to also seeking a livelihood. I am just very proud of him as a constituent and a fellow human being.

I thank you.

**Ms. Oakar.** Thank you.

Please proceed, Harvey.

## STATEMENT OF HARVEY KUSHNER

**Mr. Kushner.** Thank you both.

I'd much rather be home waiting and doing my thing and have her here doing this instead of me.

Congresswoman Oakar, Congresswoman Morella, Congressman Myers, ladies and gentlemen:

As you said, my name is Harvey Kushner. I'm the fortunate guy who Rose Kushner decided to marry almost 40 years ago and start the process of my education.

In 1974, she was treated for breast cancer and wrote a book now titled "Alternatives: New Developments in the War on Breast Cancer." She created and became Executive Director of the Breast Cancer Advisory Center in 1975 to give women information and referrals about diagnosis and treatment.

In 1980, she was appointed to a 6-year term on the National Cancer Advisory Board by President Jimmy Carter and she served until 1986.

Rose became probably the most knowledgeable layperson in the whole world on all aspects of breast cancer and particularly on its impact on women and their families.

She was the most effective spokesperson and advocate for all women who are at risk as well as those who, like her, have become victims.

If this hearing does nothing else, it will demonstrate that there are many other truly wonderful women who have taken up that torch. And the mobilization of women to do something about the breast cancer budget in this country, hopefully has begun and will really take off with the June 16 race.

In January this year, after almost 16 years of fighting the disease for herself and crusading for the recognition that it has become an epidemic—Rose died of the breast cancer that started the crusade.

Before she died she consulted with Congresswoman Oakar on the objectives of this legislation. It was a high priority on her political agenda. I am here today to speak for her in support of H.R. 3251: to tell you what I believe she would say in arguing for the urgency of increasing the budget of the National Cancer Institute to add $25 million for basic research in breast cancer.

Why single out breast cancer for special attention? You've heard that over and over again today, because it is one of the greatest killers of women in the United States; and because the total funds available to the NCI for research dedicated to breast cancer is shamefully little considering the extent of this epidemic and the effects on its victims and their families.

Ask any woman to name the disease she dreads more than any other, and she will say "breast cancer," the plague that will strike 1 out of every 10 women in this country.

You've already heard the terrible statistics of breast cancer. Of real concern is the fact that the incidence of breast cancer—that is the number of new cases per 100,000 women discovered each year—has been growing steadily for decades, and especially in recent years among younger women.

While other cancers can be more lethal in the short term, the magnitude in terms of the huge numbers of people affected, especially young children who are too often left motherless, and the direct and indirect monetary costs are devastating problems for our society.

In the 16 years since Rose Kushner discovered her breast cancer, more than 1½ million other women have become victims, and almost 600,000 other women have died while she fought her losing battle.

Unlike lung cancer, which is caused by smoking, and only just replaced breast cancer as the second greatest killer of women, there is no way known today to prevent breast cancer.

We do know that early detection, aided by mammography, offers women the only real hope of being cured; and without the need for the mutilating breast amputations that have terrorized women for millennia. This real breakthrough in knowledge came from NCI research programs after many years of research and clinical trials. But women with advanced cases of breast cancer cannot now share that hope of cure.

We also learned through many years of NCI-funded research and clinical trials that, in addition to surgical removal of tumors that can be felt or imaged by mammography, chemotherapy, hormonal therapy, and radiotherapy can extend the lives of many breast cancer patients.

My wife, Rose, was one of those women who benefited from the results of that research. But the disease finally took her life, as it eventually does to women whose cancer recurs or who are initially diagnosed in advanced stages of breast cancer. Even the most effective clinical treatments available today cannot offer them the hope of cure.

This is why it is so urgent that we invest more money in promising new areas of basic research that have the potential to lead to new therapies that might cure breast cancer, and in prevention.

Why is $25 million more for breast cancer so urgently needed?

The fiscal year 1990 NCI budget estimate for research dedicated to breast cancer, as you've heard, is $77 million. This is only 3⅓ percent more than the actual budget for 1989. The President's proposed budget for fiscal year 1991 is $80 million, only a 4 percent increase—increases that hardly keep up with inflation.

Because of this, the NCI will not have enough money for many new and promising research opportunities that are no longer dreams but are ready to be developed.

Just a few years ago, the NCI budget permitted funding more than one-third of all approved research grant applications—applications considered to be promising enough to justify funding support if money is available.

This year, the budget will only permit a little more than one-quarter—26 percent—of approved research proposals to be funded, and even then, as you've heard, at reduced levels of the requested funds: 10 percent reductions for competitive grants in 1990, and double that, or 20 percent reductions in fiscal 1991.

Think of the shocking meaning of this! Almost 3 times as many approved research opportunities with promising expectations are being denied support as are being funded. No wonder more scientists are giving up breast cancer research and young scientists are going into other areas.

The additional $25 million proposed by this legislation would make it possible to reverse this serious adverse trend. More money can generate more research answers and faster progress by enabling the NCI to fully fund grants and projects that now have to be denied support or deferred. More research dollars will also help attract, train and retain the scientists who are the key resource for new ideas and solutions.

More money can help accelerate the transfer of new medical knowledge and technology from laboratories into the clinical stages of research that can begin directly to benefit patients. And more money can increase the attention given to research on prevention, especially the role of diet and nutrition.

Is an increase in the NCI budget to add $25 million justifiable against the competing demands for funds? You've heard the answer here today—it's an absolute yes.

In terms of the more than 1 million women who have or have had breast cancer and are still living every day with its terrible threat, the total investment in all NCI breast cancer programs will then still be only a little more than $100 per patient, per year.

According to the National Center for Health Statistics, the annual direct medical costs to our society of breast cancer are now about $2½ billion—that's $2,500 per woman, per year living with breast cancer; and that is not counting the costs that occur before diagnosis of cancer, or the indirect cost to society, or the losses to their families of the more than 40,000 women who now die from breast cancer every year. Added all together, they bring the estimate of total annual cost to almost $8 billion.

In summary, what we are asking the Congress to do through this legislation is to commit to an annual investment of less than 2 percent of the annual direct cost of breast cancer—only about ½ of 1 percent of total cost—to research to find a cure.

There's an enormous "peace" dividend waiting if we will only first truly declare war on breast cancer.

My wife Rose Kushner spoke not just for all women, but for all of us: husbands, fathers, and sons, as well as mothers, daughters, and wives.

As a witness at the Senate hearing in 1988, she said, and I quote:

"Breast cancer has become a political issue in the United States. Women compose more than half of the U.S. population, and we have a right to expect our representatives in the Congress to do whatever they can to help us."

I repeat that message to you today. Increasing the NCI budget for breast cancer research by an additional $25 million will be a responsive act to help all women—in fact, to help all of us. It is still not enough, but it will be a very important beginning.

Thank you for this opportunity to testify on Rose's behalf.

[The prepared statement of Mr. Kushner follows:]

# TESTIMONY OF HARVEY D. KUSHNER

CHAIRMAN, BOARD OF DIRECTORS
BREAST CANCER ADVISORY CENTER
KENSINGTON, MARYLAND

BEFORE

THE HOUSE SELECT COMMITTEE ON AGING
SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

MAY 16, 1990

Congresswoman Oakar, Distinguished members of the Committee, Ladies and Gentlemen:

My name is Harvey D. Kushner. In 1974, my wife, Rose Kushner was treated for breast cancer and wrote a book now titled Alternatives: New developments in the war on breast cancer. She created and became executive director of the Breast Cancer Advisory Center in 1975 to give women (and men) information and referrals about diagnosis and treatment. In 1980, she was appointed to a six-year term on the National Cancer Advisory Board (NCAB) by President Jimmy Carter and served until 1986. Rose became probably the most knowledgeable lay person in the world on all aspects of breast cancer and particularly on its impact on women who have the disease and their families. She was the most effective spokeperson and advocate for all women who are at risk as well as those who, like her, have become victims of breast cancer.

In January this year, after almost 16 years of fighting the disease for herself and crusading for recognition that it has become an epidemic -- one of the most destructive causes of death of women in this country -- she died of the breast cancer that started her crusade.

Before she died she consulted with Congresswoman Oakar on the objectives of this legislation: It was a high priority on her political action agenda. I am here today to speak for her in support of H.R.3251: To tell you what she would say in arguing for the urgency of increasing the budget of the National Cancer Institute to add $25 million for basic research in breast cancer.

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WHY SINGLE OUT BREAST CANCER FOR SPECIAL ATTENTION?

Because it is one of the three greatest killers of women in the United States; because the incidence of new cases is growing every year and striking younger and younger women; because the number of women dying from breast cancer is growing year after year; and because the total funds available to the NCI for research dedicated to breast cancer is shamefully little considering the extent of this epidemic and the affects on its victims and their families who are suffering from it.

BREAST CANCER !

Ask any woman to name the disease she dreads more than any other, and she will say breast cancer, the plague that will strike one out of every 10 women in this country.

According to the National Cancer Institute (NCI), before 1990 ends 150,000 new cases of breast cancer will be diagnosed in the United States -- almost 6 percent more than in 1989; and 44,000 more women will have died from the disease -- 1,000 more than in 1989. Once again the annual toll will be greater than the year before, just as it has been growing year after year without change.

Of real concern is the fact that the incidence of breast cancer has been growing steadily, and especially in recent years among younger women. While other cancers may be more lethal in the short term, the magnitude in terms of the huge numbers of people affected, especially young children , too often left motherless, and the direct and indirect monetary costs are devastating problems for our society.

In the 16 years since Rose Kushner discovered her breast cancer, more than 1-1/2 million other women have become victims; and almost 600,000 other women died while she fought her own losing battle.

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Unlike lung cancer which is caused by smoking, and just recently replaced breast cancer as the second greatest killer of women, there is no way known today to prevent breast cancer.

We do know now that early detection, aided by mammography, offers women the only real hope of being cured; and without the need for the mutilating breast amputations that have terrorized women for millennia -- a real break-through in knowledge that has come from the NCI after many years of research and clinical trials. But women with advanced cases of breast cancer cannot now share that hope of cure.

We also have learned through many years of NCI-funded research and clinical trials that, in addition to surgical removal of tumors that can be felt or imaged by mammography, chemotherapy, hormonal therapy, and radiotherapy can extend the lives of many breast cancer patients. My wife, Rose, was one of those women who benefited from the results of that research. But the disease finally took her life, as it eventually does to women whose cancer recurs or who are initially diagnosed in advanced stages of breast cancer. Even the most effective clinical treatments available today cannot offer them the hopee of cure.

This is why it is so urgent that we invest more money in promising new areas of basic research that have the potential to lead to new therapies that might cure breast cancer. And, because breast cancer is such a complex disease, it is important to invest more money in the areas of research opportunities that can lead to effective technologies for predicting which individual patients will benefit from different therapies, and also who would not be helped by those which are highly toxic.

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WHY IS $25 MILLION MORE FOR BREAST CANCER SO URGENTLY NEEDED?

The 1990 NCI budget estimate for research dedicated to breast cancer is $77 million: This is only 3-1/3 percent more than the actual budget for 1989. The President's proposed budget for 1991 is $ 80.1 million, only a 4 percent increase -- increases that hardly keep up with inflation. Within this overall budget, basic research gets only 20 percent of the total funds.

Because of this, the NCI will not have enough money for many new and promising research opportunities that are no longer dreams but are ready to be developed.

Just a few years ago the NCI budget permitted funding more than one-third of all approved research grant applications (applications considered to be promising enough to justify funding support if money is available). This year, the budget will only permit a little more than one-quarter (26%) of approved research proposals to be funded, and even then at reduced levels of the requested funds (20 percent reductions for competitive grants in the 1991 budget, double that in 1990).

This means that support is being postponed or denied to almost 75 percent of the promising ideas and the scientists behind them that are approved by the NCI's review process.

Think of the shocking meaning of this: Almost three times as many approved research opportunities with promising expectations are being denied support as are being funded! No wonder more scientists are giving up breast cancer research and young scientists are going into other areas of research. We are losing forever the potential they hold for finding answers that are desperately need.

The additional $25 million proposed by this legislation would make it possible to reverse this serious adverse trend and recognize the urgency

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and the life-saving promise of the NCI's breast cancer research programs.

More money can generate more basic research answers by enabling the NCI to fully fund grants and projects that now have to be denied support or deferred. More research dollars will also help attract, train and retain the scientists who are the key resource for new ideas and for making faster progress in finding answers.

More money can help accelerate the transfer of new medical knowledge and technology from laboratories into the clinical stages of research that can begin directly to benefit patients. And more money can increase the attention given to research on prevention, especially the role of diet and nutrition.

Is an increase in the NCI budget to add $25 million for basic research in breast cancer a justifiable investment measured against all the competing demands for funds? The answer is an emphatic yes!

In terms of the more than 1 million women who have or have had breast cancer and are still living under its terrible threat, the total investment in all NCI breast cancer programs will still be only about $105 per patient, per year, but then 40 percent will be directed to basic research.

According to the National Center for Health Statistics, the annual direct medical costs to our society of breast cancer is at least $2 billion , more than $2000 per year, per woman living with breast cancer; and that is not counting the indirect costs to society or the losses to their families of the more than 40,000 women who are dying from breast cancer every year.

In summary, what we are asking the Congress to do through this legislation is to commit to an annual investment of only 2 per cent of the annual direct cost of breast cancer to basic research to prolong and save the lives of its millions of victims.

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Rose Kushner spoke not just for all women, but for all of us. As a witness at a Senate hearing in 1988, she said: " Breast cancer has become a political issue in the United States. Women compose more than half of the U.S. population, and we have a right to expect our representatives in the ...Congress to do whatever they can to help us."

I repeat that message to you today. Increasing the NCI budget for breast cancer research by an additional $25 million will be a responsive act to help all women -- in fact, to help all of us. It is still not enough: But it will be a very important beginning.

Respectfully submitted,

Harvey D. Kushner
Chairman, Board of Directors
Breast Cancer Advisory Center
Kensington, Maryland

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**Ms. OAKAR.** Thank you very much, Harvey, for your wonderful testimony.

I am going to ask my colleagues to go first since I have somewhat monopolized this hearing, and I apologize for doing that.

**Mr. MYERS.** It's the chair's prerogative, isn't it?

**Ms. OAKAR.** I guess; but I am really appreciative of your interest. You were my Minority Leader in this very room when we shared our cochairmanship of compensation for Federal employees, and you were outstanding. As far as I am concerned, you'd be a Chair of anything, John.

Congresswoman, did you have questions for our panel?

**Mrs. MORELLA.** I'm going to have to leave but I wanted to hear what they had to say, and I want to congratulate them again.

I am not officially a member of this subcommittee—I'm a member of the total committee—but since I've been so involved with you and you've been such a leader in this issue—

**Ms. OAKAR.** —You've been terrific.

**Mrs. MORELLA.** I think Congressman Myers and I are both here because of our intense interest.

I think you spoke very eloquently, Harvey, in terms of the need for that increase in NCI for what we can for research.

I was interested in a statement that was made earlier—I can't remember whether it was Ms. Dingell or Ms. Carter who made the statement—which said that, if over a period of 5 years we put in something like $25 million into the research, we will have a cure.

I wonder if I might ask Dr. Broder and Dr. Lippman if they would like to comment on that? I remember hearing the prognostication of Dr. Lippman.

**Dr. LIPPMAN.** Debbie was quoting me. What I said to her was that I feel that there are major centers of excellence for breast cancer, by no means the only places where wonderful work is going on, but places where over the years traditionally some of the most important studies have emerged.

And what I suggested—which may sound outrageous in terms of the monies involved—was that for approximately half a dozen of these centers, to have unrestricted funds of about $5 million a year over a 5-year period—that's where she got that—5 times, 6 times 5, for $150 million.

I believe that that kind of funding would result in a fundamentally different approach to the disease and altered therapies. I don't want to quite use the word "cure" but I would come mighty close to saying that. I just don't think we are at the point in terms of our investigations of human malignancy where we are just looking for some other leaf in the Amazon to grind up and hope that it's got a potion in it that will cure cancer.

We have the rational understanding; we have the technological skills, and we have the ideas. I really think that if people didn't have to spend about 85 percent of their time trying to support their research and really permitted to do it, we'd have the answers to these questions.

**Mrs. MORELLA.** Very exciting, very accessible—certainly a small amount when you talk about a peace dividend.

Just one final question and then I'm going to turn it over to my senior colleague here.

I've always been interested and curious about the working together that goes on at the National Cancer Institute and the Lombardi Cancer Institute. Do you do some sharing? How do you work that out?

**Dr. Broder.** I'll respond to that. We not only do sharing, we allow them to be fruitful and to multiply.

The Lombardi Center is a functional component of the National Cancer Institute, in that most of our very distinguished employees in breast cancer have now relocated themselves to that Center.

**Mrs. Morella.** I know, I know.

**Dr. Broder.** So I consider this the highest contribution we possibly can make to a center.

**Dr. Lippman.** I'd like to also respond because I'm deeply grateful to the support of the Cancer Institute, but I'd like to give as a single example—and this not meant as a comment about Sam at all, but the current funding situation.

We applied for a Cancer Center support grant—that is a grant which the Cancer Institute provides to a Cancer Center to enable it to continue to coordinate its research.

We applied for a grant in terms of approximately $1½ million per year. When that grant was reviewed it was approved at approximately $1.3 million per year for 3 years.

As a result of funding situations that are simply no fault of anyone—except that the money isn't there—we're going to receive approximately $800,000 a year for 2 years and 3 months, which means that much sooner, with much less money, we're going to have to do it again.

Now the good news is we are the only new Cancer Center in the United States this year to receive this funding. I'm honored and delighted. And that means that we were able to successfully compete. However, that's half the money for less than the time that we need it. So what that means is that my colleagues and I are simply going to have to turn around immediately, cap in hand, and start to do the whole process over again, sooner and with other people.

So that there's good news and bad news, but it's very difficult to carry on a chronic effort to cure cancer when at every turn one is simply trying to pay the rent.

**Mrs. Morella.** So sometimes that little seed money requires replanting instead of, you know, as you said earlier, growing a little at a time and just a little bit slower.

I want to thank all of you for being here, and I want to thank Dr. Henderson for the work that she's done—we really appreciate that, as a woman who is a human being. Thank you.

Thank you, Madam Chair.

**Ms. Oakar.** Thank you very much.

Let me call on Mr. Myers at this time.

**Mr. Myers.** Thank you, Madam Chairman, and thank you for allowing me to be here today, inviting me to participate because of my personal interest. My wife has been to both Dr. Broder and Dr. Lippman and now is under treatment, of course, with Dr. Lippman, so I have an interest in their work and the work all of you are doing.

Mr. Kushner, I hope I never sit there like you're sitting there today; I hope I'll have a better story—but our prayers and our thoughts are with you. I didn't have the privilege of knowing Mrs. Kushner, but from what I have heard about her, she certainly was a very strong person and an inspiration to you and to all of us, and we certainly are grateful for your willingness to share today, and for the contribution that she made. Our job has been made a little easier in getting converts because of the people that suffered, like you and her.

I serve on the Appropriations Committee that finally has to make the decision how your tax dollars are spent. It isn't an easy task. I've never found anybody yet to come before us who ever had enough money. I know that our responsibility and our task is to prioritize the limited number of dollars that we have.

We have the President's budget—it's dead on arrival. I've been here for 24 years and every budget has been dead on arrival when it gets here—it's a recommendation. We've always reorganized it; so we are in the process of doing that right this very moment, of trying to prioritize the budget. But there just are not enough dollars available to do all the things that are required from the Federal Government.

I just looked at my card here; I have 7 patients coming in this afternoon, after 4:30—patients because they're all people pleading for more money; they're in trouble; they need money for projects; they need money for their programs. And on Appropriations, they come to me to say, you're going to be marking your bill up, so we need that help.

The first 4 months of this year, we've sat in testimony like this, hearing witnesses come up—usually about 1 to 5 minutes, every witness who comes up has asked for more money this year. So we have a real task of prioritizing.

I think you're going to get your $25 million. You have my ear, anyway, and I'll be working to do that.

But I'm interested in just where that $25 million will go. I don't understand. Dr. Broder, do patients who come to NCI pay for the treatment they receive there, or for the care they get?

**Dr. Broder.** No, sir, that's an exceptional facility. The NCI is part of the National Institutes of Health, as is the clinical center, which is a research hospital. To my knowledge, it is a unique hospital and is a resource to the country and to the world. It's designed especially for research studies involving human beings, and particularly it's designed to push the outer envelope of new knowledge, whereupon, the new knowledge is transferred to other centers.

The patients who go to the clinical center who are on an approved protocol—that is an experimental study do not pay for the experimental medical care which is provided.

**Mr. Myers.** If my wife had been treated there—if she had elected to come—she would not have paid? You know, we could well pay; we could afford to make the payments. She would not have paid? That didn't enter into the decision she made, but it should have.

**Dr. Broder.** The tradition at the clinical center is that patients are accepted on the basis of their eligibility for an experimental protocol. We feel that this provides the fairest mechanism to all parties and permits patients across the waterfront to come to our experimental studies without consideration of a financial issue.

And in all fairness, the only thing that I can say is whereas we feel we make considerable progress with our experimental therapies, technically they are experimental. They're not standard care; they may be state-of-the-art experimental care—we're pushing the outer envelope. There is a possibility that any patient who enters an experimental therapy could undergo a research-related injury or risk.

So the totality is that we feel that in fairness and within the tradition and the efficiency of our operation, we have not introduced a cost factor. The predominant care that we give is experimental and would essentially not be reimbursable by third parties or other payers, and so on. This has been the tradition of the National Cancer Institute within NIH.

I personally feel it has worked well. It has provided us with an important resource and has permitted us to make considerable real progress.

Mr. **Myers**. Then I'm correct in assuming that no patient pays?

Dr. **Broder**. That's correct.

Ms. **Oakar**. Would the gentleman yield on that?

Mr. **Myers**. Certainly, of course, you're the Chair.

Ms. **Oakar**. I'm in the process of learning how this operates, too. John, if you take the NCI budget total for breast cancer programs of $77 million, and we'll break it down. I'll give you the sheet. I'd like to submit this for the record.

[The document follows:]

## NCI BREAST CANCER PROGRAMS BUDGET DATA

(FROM NCI BUDGET OFFICE)

PROGRAM BREAKDOWN
DOLLARS ($) IN MILLIONS

| FISCAL YEAR | 1991 BYPASS ADD-ON | BASIC RESEARCH | DETECTION | EPIDEMIOLOGY | PREVENTION | REHABILITATION | TREATMENT (W/TRIALS) | NCI BUDGET TOTAL |
|---|---|---|---|---|---|---|---|---|
| 1991 | 111.0 | 16.9 | 18.2 | 12.3 | 8.4 | 0.8 | 23.5 | 80.1 |
| 1990 | – | 16.2 | 17.5 | 11.8 | 8.2 | 0.8 | 22.5 | 77.0 |
| 1989 | – | 15.7 | 16.8 | 11.5 | 8.0 | 0.7 | 21.8 | 74.5 |

President's Budget
Estimate
Actual

Mr. **Myers**. Is this the one?

Ms. **Oakar**. You have it right in front? Right.

What I'm trying to do, anyway, with my bill is, to beef up the $16.2 million, which is all we spend for basic research. It's true that all of this works together and so on. But detection is 17.5, and prevention is 8.2, and .8 is rehabilitation—they're all very important. And having individuals who allow themselves to be experimented on and to be studied is very important.

But in terms of the actual basic research, we only spend on this terrible disease, $16.2 million. That's really what I'm trying to target. I wish we could do more in every area.

Mr. **Myers**. That's what concerns me. As I mentioned earlier, in Appropriations hearings I inquired about the monies that are being appropriated or being requested to be appropriated from the Appropriations Committee—the research for heart, cancer, and other diseases. There's just never enough in any of these areas. It's something that concerned me—that $16.2 million could be much more than that, possibly, if patients that could pay, paid. However, this isn't the place to get into that discussion.

Dr. **Broder**. Sir, with respect, if I might just interject on this point.

I believe that perhaps we're mixing apples and oranges with respect to the number of patients that go to the clinical center and our ability to recruit patients to the clinical center would very likely not really enter into these statistics. The specific sidebar issue would be that if we were to impose a charge, we might in effect detract from our research efforts.

Mr. **Myers**. Do you do a financial check on them or their ability to pay? Do you do that, on the patients, is that part of the criteria?

Dr. **Broder**. A very high percentage of our patients have come at a point in time when they've exhausted all standard types of therapies and a considerable percentage of them would not be in a position to pay.

Mr. **Myers**. I'm not suggesting every patient be charged a minimum fee; but those that could should be charged. Hospital officials come in and testify before us all the time and they admit that the patients that can pay do pay—doctors come in and tell us, other types of physicians come in and say they charge on a scale—if you can pay, you pay; and that takes care of the person who can't pay.

This isn't the point to make that decision. But since we're looking for more money—if my wife had been treated out there, Dr. Broder, I feel that she should have paid. We didn't ask the question when she came by. But I personally feel that she should have paid for her service.

Dr. **Lippman**. Mr. Myers, I think it's a terrific attitude, but let me give you an example. We've already heard today that one of the major advances in treatment for breast cancer, which is still in some ways experimental—is bone marrow transplantation.

There's no question, none, that for women who have about a 5 or 10 percent chance of responding to any other therapy we have, the response rates to this therapy have been published in many centers in the 70 percent range. It is a fact that essentially nowhere in America will any third-party payers reimburse for this treatment—and that will cost about $50,000 a patient.

So that a critical issue, when you say, could we look and see if people are willing to pay, is the fact that third-party payers will not pay for what they call "experimental" therapy. And yet, it is certain that for many patients with cancer, the greatest hope that they have, the state-of-the-art for them is an experimental therapy, because what we have, under many circumstances, is inadequate.

So that while it is possible to imagine that some people might be able to afford experimental treatments, most Americans who rely on health insurance, or don't even have it, would simply be bankrupted by such a policy.

Furthermore, it's only really a small number of patients who are actually seen at the clinical center compared with the thousands of women who are on experimental treatments supported by the National Cancer Institute throughout the country.

Mr. MYERS. Isn't it all pretty much experimental; all treatment, today?

Dr. LIPPMAN. No.

Mr. MYERS. It isn't?

Dr. LIPPMAN. There are many treatments for patients with cancer. Half of all patients with cancer are cured by traditional surgical and radiotherapeutic means, and those aren't really considered experimental.

Third-party payers reimburse for traditional adjuvant therapy of breast cancer for chemotherapy, of Hodgkins disease, testicular cancer, for example—traditional drugs used in traditional ways. Oftentimes, however, with many diseases: lung cancer, gastric cancer, pancreas cancer, colorectal cancer—these therapies are simply inadequate. And the best hope for these patients is a new development, a new trial, and third-party payers will not pay for those patients.

Mr. MYERS. Haven't we pretty much whipped testicular cancer?

Dr. LIPPMAN. The survival has dramatically improved, largely through funded research.

Mr. MYERS. I'm not suggesting that this is the point to consider this, but we're talking about user fees—and those of us on Appropriations struggle with this all time, trying to find more dollars. We have looked at user fees. We have imposed user fees where it can be done; so that's what I guess I'm talking about. It's not my role to do it at this point.

In any event, I don't quite understand. Are there 6 Cancer Centers? Dr. Lippman, you and I have talked but it's always been professional; are there 6 National Cancer Centers? Someone mentioned 6, times 5, 30, what will the 6—

Dr. BRODER. Sir, there are 56 NCI-funded Cancer Centers. This is a major commitment of our program. As I mentioned, there are 3 foundation stones of the National Cancer Program. There's basic research, which consumes approximately half of our budget. So in excess of $750 million was committed to basic research. The overwhelming majority of that falls into the definition of what is called "investigator initiated basic research." And what most people mean when they use that term is the kind of laboratory work that generates new knowledge and new technology that helps us develop new insights on a molecular, genetic, and other basis. So one of the foundation stones is basic research.

Most people will concede that for virtually any disease, that basic research is the ultimate tool by which ultimate victories are given. And if you will permit me to use a rather old metaphor: Basic research allows you to come up with Salk vaccines as opposed to perfecting an iron lung. So that makes a definitive solution to a problem eventually.

I think the U.S. leads the world in the genius of the people who can conduct basic research. We are very blessed with having brilliant scientists in our program who receive funding. And as I mentioned, approximately 50 percent of our budget goes for that mechanism.

Then there's the Cancer Centers Program—another very important foundation stone. There are approximately 56 current Cancer Centers. Each of these centers conducts interdisciplinary research. Dr. Lippman's center has recently become such a Cancer Center. But there are several Cancer Centers in the Washington Metropolitan area. Johns Hopkins University is a Cancer Center, for example.

We try to ensure that there is appropriate Cancer Center support. We feel that centers serve a very critical mission. They do research, they do training, they do community service and outreach. They represent the National Cancer Institute in their communities.

The final foundation stone is clinical trials. We have a program of 50 or 60 centers throughout the country which conduct important clinical trials on treatment research. They are the way that we implement an idea from the laboratory to the bedside and make it work. They are the way we decide what works; what becomes standard therapy; what may be too toxic or ineffective in which case we discard it; or what may become standard state-of-the-art treatment.

We learn, for example, that lumpectomy and radiation would permit women to spare their breasts and do not need to have mutilating surgery by a function of these clinical trials operations.

In the future we hope that we can expand the clinical trials concept so that it is more representative of both prevention and treatment research because we think both are important.

So those three are the foundation stones of the National Cancer Program. We feel they all must work together much as the foundation stones of a large building—you can't only have one or two working to hold up the building; you have to have everything working together.

Mr. MYERS. So the Cancer Centers have to come through you for their grants, through the NCI?

Dr. BRODER. Yes, sir. Cancer Center interdisciplinary programs are funded through the National Cancer Institute and they are a special kind of grant mechanism.

Mr. MYERS. If I may use the analogy: somewhat like a wheel, that you're the center, and there are spokes out—then these people ought to relate back. And to answer Mrs. Morella's question: They report back to you the accomplishments and the success they're having, or problems they're having, or at least the work they're doing in a certain type of research.

Dr. BRODER. We are responsible for distributing and for the proper management of public funds. But I wouldn't necessarily want to say that we are the center. I feel that this country is blessed with formidable intellects that are present in every State and at every medical center, and throughout every region.

I wouldn't want to say that there's some central governmental authority, which is called the National Cancer Institute, that somehow directs research. It's actually quite the opposite. We want to listen to our peer community. We want to make sure that we're listening to the brilliant intellects which exist in this country; and that we, of course, feel that if the buck stops with us, I have to account to the Members of Congress for how we progress and how we use the monies.

But I wouldn't want to leave you with the impression that we're some sort of centralized governmental authority that knows everything and that operates on that basis. We operate on a basis of peer review.

Mr. **Myers**. I see you may be a good doctor if you're not much of a mechanic. Take a few spokes out and that hub's going to be right down on the ground.

Dr. **Broder**. Sir, I must confess that I don't have good mechanical skills, but I will accept your assessment that I'm a good doctor.

Mr. **Myers**. I didn't suggest that it was centralized. I meant that everything had to come back to the—

Dr. **Broder**. We feel that everything does come through us. We have very careful coordination. We care about our grants management, and we are worried about a number of issues. And, yes, we do take very great pains to make sure that we manage, and that we efficiently manage resources and avoid overlap; and in particular that we share knowledge from multiple sources across the country so that we don't have one person going off without knowing what another person's doing.

We are particularly sensitized to redundancy and overlap. We want to spend the Government's money efficiently.

Mr. **Myers**. That's our task, yes.

I didn't mean to be disrespectful about your medical expertise. I referred to a spoke—maybe my analogy wasn't too good; but spokes are very important to a wheel, too, and the hub merely centralizes it.

Anyway, I will use my appropriation hat now. We constantly have to prove to our constituency as well to other colleagues in the Congress before we can get an appropriation to pass—the benefit cost, BC. We have to show accomplishments before. So with something like this it's very important that you relate to us and tell us as we told you when you appeared before the Appropriations Committee, the accomplishments and the likelihood of accomplishment.

And I was interested in both of your comments about more money that you could make a breakthrough in the next half a decade, or the next 5 years. If you have more of an explanation—if you want to include it in the record, I would be pleased to see this, because I think this is something we're looking to. If we knew just how much money it would take, and you could have something 5 years from now, I don't think there's any question that we on Appropriations would put that money in there.

Dr. **Broder**. Sir, at the risk of perhaps being misunderstood, I feel strongly and passionately—

Mr. **Myers.** You and I are having a communication problem, aren't we?

Dr. **Broder.** No, I don't think so. I think we're okay.

At the risk of being misunderstood—not by you but perhaps others—I feel passionately committed to the National Cancer Institute, and I've devoted my entire life to it. I feel it is an important component—we will make progress.

Perhaps I could introduce for the record—we have made considerable progress in individuals under the age of 65, for example, in reducing the death rate. We need to do more for people over the age of 65. We do more for underserved populations. We need to do more for rural populations, to make sure that all of our technologies are going out where they should be.

I feel very strongly that the resources the Congress gives us will be wisely spent and will be efficiently spent, and will give a return to the America people.

But I hope that we do not do so under the assumption that we can give you a specific timetable. This will be a lot of hard work. I can promise you that whatever resources are given, we will make progress. We will make meaningful progress, and we'll make progress in breast cancer. But I cannot promise you that with any allocation of resources which the Congress might be willing to give us that we would have a cure for breast cancer within a certain amount of time.

Mr. **Myers.** We have trouble in Appropriations with time and dollars, estimating how much.

I will close with this: One of the committees I serve on is responsible for Nuclear—Nuclear Medicine, too, by the way, is included in our committee, and the fusion reactor. Twenty years ago we had the promise within 10 years we would have a fusion reactor—nuclear reactor. We haven't got it yet; we're not even close to it. We've been pouring billions of dollars into that project.

I think we will find the money for your research if we just have some hope—not assurances. Nobody can promise anything; we realize that—but we need some hope of accomplishment.

Dr. **Broder.** We appreciate your support very much. It's my privilege to be here, and I think we can promise you progress, whatever the resource allocation.

Mr. **Myers.** I've been outspoken. I guess my name has appeared in a few publications. I am getting letters from physicians around the country suggesting one is mistletoe and all the various things that they're coming up with.

Who looks at some of those things? I get about 1 or 2 letters a day from some researcher, usually some doctor someplace says, I've got it, but I can't convince NCI.

Do you ever look at some of those things? Maybe they do have some validity. And how much time do you devote to those kind of things?

Back home I call some of them "quacks." I don't know whether that's a proper phrase or not, but everybody has got some idea. We also deal with that carburetor that will get 100 miles to a gallon, too, but the oil companies buy it up.

Is that somewhat similar to some of these people who come up with some of these ideas to cure cancer?

Dr. **Broder**. Sir, we receive many more claims for cures of cancer than really exist. We feel that we have one of the things that we need to do to make sure that we have an efficient program and manage taxpayers' money efficiently, is to make sure that we look at new ideas; that we have a level playing field; that we keep an open mind; that we don't dismiss any possibility, but that we have a hard look at the realities of it and that we use our peer review process. We feel that this is the most efficient way to protect the taxpayers' money.

Mr. **Myers**. Thank you very much for all of your testimony today.

Dr. **Henderson**. Madam Chairman, may I make just three brief points for the record?

Ms. **Oakar**. Certainly.

Dr. **Henderson**. The first thing is that I understand that when in your bill you say basic research you include prevention research. And I also would like to make it clear that we can prevent disease before we have all the detailed information from molecular biology. We are currently preventing lung cancer by cutting down smoking rates and we have not yet worked out at the molecular level how cigarette smoke exactly causes lung cancer.

The third point I'd like to make is that when it comes to prevention research, you can't do it any quicker than it takes for the cancer to grow so you can show it doesn't occur. So there is a necessary minimal lenght of time it takes to do prevention research because of the growth rate of cancer.

Ms. **Oakar**. And in older people it grows more slowly sometimes. We're talking about the changes in that.

Mr. **Myers**. Madam Chair, I thank you for having this meeting and inviting me to participate and allowing me to ask all my questions.

Ms. **Oakar**. I'm delighted. I want to say for the record, just to put it in perspective about what we spend on breast cancer. And, again, this is not meant to rival what we spend on AIDS research. I am very supportive of AIDS research and always have supported. But AIDS has the largest budget at NIH, which is the umbrella organization. It's currently funded for $1.6 billion. This is currently funded for $77 million. Breast cancer research is funded for about 5 percent of AIDS research. And in the authorizing legislation of the budget that was just passed, which I supported, they added another $700 million; which is terrific, I'm all for it.

But I think that since 1980 we've had 54,000 Americans die of AIDS, and we had 300,000 Americans die of breast cancer. Now there is not the same priority given to a disease that is causing far more deaths. I realize they are different—one is contagious; one apparently is not, who knows? There's some research I've read that suggests that that may not be quite true. So we know that some people like myself, since I have a sister who has had breast cancer, at higher risk, et cetera.

But that isn't even the issue. It's a question of real priorities. And all I'm saying is, what I'm asking for in this little bill—and I wish it would be the $150 million, which I heard Dr. Lippman ask for—$150 million for 5 years, consistently for 5 years, which is one-fourth, a little less than one-fourth of what we just increased AIDS for; I mean, you know, it's just a question of what are we doing here?

I see budgets where we have requests for a billion dollars more in Star Wars research. If I asked my constituents: Would you rather have more research in breast cancer and other related diseases than Star Wars? I've got to tell you, they'd say: Please find a cure for breast cancer; it has devastated my family.

All I'm saying to my colleagues—and that's part of my frustration—is that somehow we haven't gotten the message out there—and a disease that so many people devoted their lives to. And I'm, frankly as chairing this committee, allowed by my distinguished chairman of the full committee, the former chairman of the full committee, Mr. Pepper, who was responsible for so much legislation relating to these institutes—I have to say that I get very frustrated, because last year we put in mammography coverage in the Catastrophic bill because it was the only way I could figure how to do it; and we did it.

And in conference, with no women there—not that women would have been the only ones to defend it—they took it out. They could have added it to Medicare coverage. And we know that it would have saved a lot of money and saved lives. It cost $10,000 or less when you catch cancer at an early stage as opposed to $125,000 per patient when you catch it in an advanced stage. We could have done that and already saved a lot of lives. We didn't do that.

I just see all of this money into other areas of research and very little funding for research here. I was a member of the Pepper Commission. And you know, John, it does make a difference. I was one of 15 members; I was the only woman on there; and the Pepper Commission, or they wouldn't have gotten my vote, on the 8 to 7 vote. They put in all the suggestions I made or they wouldn't have had my vote. But if I hadn't been there—and I'm not talking about me, you know, per se. I was inspired by, obviously, others. I mean, I'm sort of parroting Rose Kushner, Nina Hyde, and some of the people who were witnesses here today, because I'm not an expert in this area. I'm a lay person. But I know darn well that women have not addressed this subject in the manner in which they should.

I really believe strongly that the commissioners would not have recommended the $30 million that we did recommend for breast cancer research if I hadn't put a gun to some of the Members head and said, I'm not supporting that recommendation. I do get angry at the feminist groups as well, at our female-dominated organizations because they do not make health care an issue in this country. And breast cancer and other related issues ought to be an issue. If we networked all the feminist groups and all the different areas that they are concerned about—and I'm not criticizing them on other issues—but it really does disturb me that even women's organizations do not make this an issue when it devastates so many women in this country and their families.

So forgive me for my frustration, but I wish that the other types of research, whether it's for the Defense Department or for other areas of medical research, since 90 percent of all the research done in this country relative to health care is government-sponsored, I wish there were the scrutiny given to all these other areas that there is on this one little minuscule item that we're asking for. It is totally frustrating.

And, frankly, when I see the death of people like Nina Hyde and Rose Kushner, who are not around to push people like myself and others, I wonder what will happen.

I'm thanking you in advance for your commitment, John, on the $25 million. You know, you're terrific. And I think the questions you've asked are fair questions. But, boy, when you get in that back room of the Appropriations Committee, remember this hearing.

Mr. MYERS. We'll be there an hour from now.

Ms. OAKAR. Okay, thank you very much, John.

Mr. MYERS. I have to leave for the conference with the Senate.

Ms. OAKAR. And get them as well because they could have done more. I'm very disturbed that we didn't keep mammography coverage for Medicare.

If I could just relate one other thing, and that is that in our country we have a crisis in health care. We have 77 million Americans with little or no health care. Who can afford to even have the coverage—if they are lucky enough to get all these kinds of sophisticated coverage to be experimented on and so on—we don't have that kind of coverage in this country. Most insurance policies, whether they're public or private, do not include prevention such as mammography, cancer screening for men, et cetera. We put that in a recommendation.

I think the only answer to that problem is national health insurance. That's just me, and I'm trying to push that.

But in addition to that, I think we've got to fund some of the research that these people need as tools. It's real easy for me to pick on Dr. Broder—and we like to do that—but I have to tell you, Doctor, even though I could quibble about what you do with $5 million of the $77, and whether or not that's really all used for breast cancer as opposed to research in other areas, I don't even want to do that because it's so minuscule to quibble about; the real answer is we need comprehensive treatment and research.

I remember Rose Kushner, Harvey, calling me, saying, you know, there's a wonderful doctor that's done all this experimentation relative and case-by-case analysis with women who took DES and now he wants to do the follow-through on the daughters. What happens to the children of women who took DES?

Rose Kushner took DES. My sister took DES. Her next-door neighbor who has breast cancer took DES. They are concerned about what happens to their children. And we couldn't even see a doctor doing this dedicated research get a grant for $60,000 to do the follow-up case-by-case study relative to the DES daughters and sons of the women who took that drug during their pregnancy. It's just amazing.

Dr. Henderson, I'm sure you're disturbed that you could not get your prevention, your intervention trials relative to diet, funded. But no more frustrated than the women who wrote all these letters on your behalf and on similar kinds of research; and I'm sure no more frustrated than Dr. Broder, who would probably like to do it, like to see NCI fund your research. So this is the difficulty we face. I'm at a point of really getting very angry about it.

One of the Members said to me—the other day we passed the Parental Leave bill; it took us 5 years—and he said, for another piece of legislation, it's chairman of this full committee, Mr. Ford—he said, for another piece of legislation, he said, oh, 5 years is nothing. He said, it took me 15 years to get another piece of legislation passed related to education.

I thought, my goodness, if we do that with respect to the research that we're trying to push forward in the area of cancer and other related diseases, think of the millions of people who will die. And, sure, people talk about limiting our terms, I'm glad that Bill Ford was around for 15 years to get the piece of legislation passed. So this is the terrific frustration we face.

Dr. Lippman, I want to ask you very quickly—and I've gotten on my soap box a little bit about this, and I'll try to do something more about it.

You mentioned that statistic of within 5 years, if you get some increase in funding, you could see a dramatic change in the options there are for women.

I have another bill that relates to options for women that Rose again inspired, that was passed in the State of Maryland. I'd like to see every doctor give women the NCI booklet, mandated to give it, so that women knew that they didn't necessarily have to have radical surgery—and it's kind of disturbing.

What are you talking about, though, when you talk about different kinds of options? Can you give us some idea?

Dr. LIPPMAN. I was specifically responding to the fact that I believe that there are easily 8 or 10 extraordinarily exciting biological ideas out there which have been shown to have profound effects on the growth of human breast cancer in model systems.

I think it will take approximately—and I realize that I'm willing to stand on a limb that Dr. Broder isn't quite willing to stand on, and I respect his caution—but I'm willing to stand on a limb that says that if this is really supported, that one or two of these ideas are going to hit genuine pay dirt for actually treating people—that these have already been extremely successful with human cancers in the test tube and with human cancers in experimental animals. They are based on rational principles. This isn't quackery; these are fundamental developments and our understanding of how cancer grows, how it invades, and how it mastasticizes.

I also want to second Dr. Henderson's comments; I quite agree with her statement that you don't need necessarily to know the cause to be able to do a great deal to prevent. And I strongly believe, and I think she would concur, that there is absolutely certain evidence in experimental animals that many of the strategies that she proposes for the prevention of human cancer have already been shown to be effective in preventing a variety of animal systems.

And I believe that this kind of research, virtually unquestionably, would reduce the clinical appearance of breast cancer in many women. It's just impossible, I think, to look at these data as a scientist—not as a polemicist, but simply as a scientist—and not feel that the only rate remitting step is the ability to carry out the work, not some conceptual need for new ideas.

Ms. OAKAR. Harvey, I wanted to ask you, Rose was responsible for creating a hotline. She, herself, was always talking to different individuals who would consult with her. And as you mentioned, she was the most knowledgeable lay person I've ever met on this issue and so many interrelated issues.

What has happened to some of the outreach work that she had been doing? No one will ever replace her. It's the same that I've said about Claude Pepper, but all of us have to try to together work on some of these things.

What has happened to some of her networking?

Mr. **Kushner**. Rose had to give up the hotline that she had some years ago, that was really being manned just by her and one other person. But there are other organizations that are doing it. Y-ME—the organization that's headquartered in a suburb of Chicago—took over what Rose started. They have their own hotline, 1-800-221-2141. It's manned by trained volunteers. One reason Rose had great difficulty expanding hers was the problem of finding women and having the time to train them. Y-ME's women are all breast cancer patients themselves, and they have been carefully trained so that they know what they can and cannot say to women, or what they should or should not say. And they also provide the possibility that women who call with different kinds of problems, experiences and situations can be matched with someone who has had that same experience.

So it is very, very successful. It's national. And it can be reached by any woman in the country. That's really the principal outreach.

Now, replacing what Rose did in lecturing and in pushing the people in the Cancer Institute, and you and everyone else, that's going to take many, many women. And, again, I think it's fortunate that you saw here today that there are many other women who have the anger now and the incentive to go do it.

Ms. **Oakar**. Thank you very much, and thank all of you.

You would be amazed at how many people have requested our hearing record from 1984 and 1986 and so forth. It's just amazing the interest in this subject. I guess now we have to do a little bit more about it.

I want to thank my colleague. John, I wanted to say for the record, that one of the finest contributions you made today, in my judgment, was your statement that related to people being afraid to talk, or are intimidated about talking about breast cancer. I think that is very true of women. I think it's true of families.

And perhaps because of the nature of the disease and how identifiable to one's femininity and that sort of thing, perhaps there is that kind of shielding.

But I think your saying for the record was very, very important. And perhaps that overt dialogue will serve us in a long way to do something about this disease in a much more comprehensive way.

Thank you all very much, and I want to thank the staff for their fine work. Thank you very much.

The hearing is adjourned.

[Whereupon, at 1:20 p.m., the hearing was adjourned.]

# APPENDIX

NATIONAL WOMEN'S HEALTH NETWORK

## COMMENTS ON FEDERAL FUNDING OF BREAST CANCER RESEARCH
## HOUSE SELECT COMMITTEE ON AGING
## SUBCOMMITTEE ON HEALTH AND LONG-TERM CARE

MAY 16, 1990

The National Women's Health Network appreciates this opportunity to offer comments on the need for public support for new research on breast cancer and breast cancer prevention. Breast cancer is the second leading cause of cancer death among women, and therefore research should be a high priority in government spending. Women's questions and concerns about breast cancer must be fully answered particularly with regard to breast cancer prevention through changes in the amount of dietary fat, and with regard to the link between breast cancer and oral contraceptives. We believe the following are necessary for effective breast cancer research:

1) expansion of public funding for research on prevention of breast cancer, including a study of the association between dietary fat and breast cancer;

2) expansion of the National Institutes of Child Health and Human Development (NICHHD) budget to include a study of the connection between breast cancer and oral contraceptives.

### BREAST CANCER PREVENTION AND DIETARY FAT

For the past 40 years, evidence from animal and human studies has suggested that dietary fat might be linked to breast cancer. 17 of 21 studies looking at people of different countries, their dietary habits, and their rates of breast cancer have found a correlation between fat intake and breast cancer. Further research is needed to confirm this causal relationship.

Within the current context of breast cancer research, breast cancer prevention is hardly a main concern. In fact, the most comprehensive cancer prevention trial in the world, known as the Women's Health Trial (WHT), was canceled. If the study had not been canceled, preliminary work would have been expanded to monitor the fat intake of 32,000 women aged 45 to 69 over a 10-year period. Half the women would have been instructed to reduce their fat intake to 20 percent of total calories, and the others would have continued on the present typical American diet, which contains about 40 percent fat.

The National Cancer Institute canceled the WHT in 1988, claiming that the study was just too risky. Some physicians were reluctant to believe healthy women would stay on a low-fat diet year after year. Just this fall, the National Cancer Institute again refused to fund a dietary intervention trial, DIET FIT. This study would have evaluated the effect of a low fat diet on breast, colon, endometrial and ovarian cancers as well as coronary heart disease.

It appears that in the eyes of researchers and doctors alike, treatment of breast cancer is more important and effective than prevention. Dr. Maureen Henderson, one of the principal investigators at the Fred Hutchinson Cancer Research Center where the WHT was to be conducted, explained that in comparison to treatment research the results of prevention seem intangible. "You can demonstrate how you have cured people, but how do you demonstrate that you have prevented them from getting the disease?" Unfortunately, due to the refusal of the National Cancer Institute to fund a clinical trial women do not have the potentially lifesaving information that they need. The Network is convinced that the only way to demonstrate breast cancer prevention for thousands of concerned women is to fund a large, long-term trial.

## BREAST CANCER AND ORAL CONTRACEPTION

From 1983 to 1986 three separate investigations reported an increased risk of breast cancer among women under age 45 who had used oral contraceptives for extensive periods of time at a relatively young age (generally before age 25). Although there have been 14 studies since 1980 that show no relationship with breast cancer risk, this evidence is not entirely reassuring to young women with long-term pill use. A number of newer studies evaluating the effect of long-term use of oral contraceptives at a young age are adding to the level of concern, suggesting a breast cancer link. No consistent pattern from a variety of findings on breast cancer and oral contraception is evident. Publicly funded research is crucial in providing a definitive answer.

Women are concerned with the lack of clear information. Recently hundreds of women and doctors signed petitions for delivery to Dr. Duane Alexander, the director of NICHHD, requesting a large, comprehensive study of oral contraceptives and breast cancer. Over 80 percent of American women between ages 15 and 40 use or have used the birth control pill. Dr. Alexander endorsed the spirit of this request, and agreed that a large scale study should be dome. But for such an investigation to take place, NICHHD's budget must be expanded. Therefore, we urge increased public funding for NICHHD so that a high quality study on breast cancer and oral contraceptives can be undertaken.

CONCLUSION

Public support for breast cancer and breast cancer prevention is essential for the health of American women. The National Women's Health Network looks forward to working with government agencies in establishing funding for research. We especially urge the government to focus on studying the link between breast cancer and oral contraception, and dietary breast cancer prevention. This year an estimated 41,000 women will die of this disease. We cannot afford to leave women's concerns unanswered.

# FINDING A LUMP IN YOUR BREAST

AMERICAN CANCER SOCIETY

## Introduction

Finding a lump in your breast, nipple discharge or other changes in the shape or appearance of your breast can be frightening. This pamphlet was prepared to help you understand the diagnosis and treatment choices for various breast lumps. Not all the information contained in this pamphlet will pertain to you. It is important to understand that the majority of breast lumps are not cancer, but only a physician can make the correct diagnosis. If you do not have a physician and want information about qualified physicians, call your local hospital or the American Cancer Society. It is your right to be informed about your condition; you should feel free to get information from your physician about your options in making decisions about treatment.

## Seeing Your Physician

You will be asked questions about your health and family history to evaluate your individual medical situation. Feel free to ask questions at this time and throughout your care. You may wish to bring someone with you to help you remember what the doctor recommends. You should receive a complete physical examination including a thorough examination of both breasts.

## Diagnostic Tests

If your doctor wants additional tests, a mammogram may be advised. A mammogram is a very low dose X ray of the breast used to help evaluate the lump, other areas in the same breast, and the other breast. There are guidelines about doing mammography for women without symptoms; however, a mammogram is always appropriate for the woman with a breast lump or other breast findings which might suggest cancer. You should not be afraid if your doctor suggests a mammogram. However, if you have concerns, discuss them with your doctor. Information on mammography is also available from the American Cancer Society. Other tests which may be suggested too should be explained to you in words that you can understand.

Many breast lumps felt by women will not be considered significant by the doctor and will need no further tests. If a lump seems suspicious, it must be determined whether the lump is benign or malignant. Your doctor may place a needle

(Reprinted with permission of the American Cancer Society) into the lump or suggest removing it. The needle aspiration test will determine if the lump is a benign cyst filled with fluid or if it is solid. A biopsy, the surgical removal of a lump or a portion of the lump for examination under the microscope to determine its nature, may be recommended. A biopsy may be done using local or general anesthesia as an outpatient or in the hospital. Ask your doctor which type of biopsy is best for you.

In the past, a biopsy was combined with immediate treatment if a cancer was found – *one-step procedure*. Now in many cases, the biopsy is done for diagnosis and the actual treatment of the cancer is done at a later time – *two-step procedure*. It may be more comforting for some patients to have the *two-step procedure* if they want time for full discussion with family, friends, and health professionals before treatment is instituted. A short delay between diagnosis and treatment does not harm your chances for cure.

## If a Cancer is Found

At the time of the biopsy or treatment, a sample of the tumor should be tested for steroid receptors. These receptors are found on tumor cells and bind to the female hormones, estrogen and progesterone. The presence or absence of these receptors gives indications of expected responses to future treatment with chemotherapy or hormones if cancer recurs or spreads.

When a cancer is diagnosed, it is important to determine its extent. This evaluation is called *staging*, and it determines which treatment method is best for you. A bone scan, X rays and blood studies may be necessary for staging. Based on the physical examination and the results of special tests, your doctor will select (from surgical procedures, chemotherapy programs, and radiation therapy techniques) the best management for you as an individual. Your doctor should inform you of these various methods and combinations of treatments, expected cure rates, possible recurrence rates, treatment effects, cosmetic results, and costs. You and your doctor may want a second opinion to be sure of the appropriateness of the treatment selected. Don't feel rushed into a decision if you wish to talk to others before deciding on your preferred treatment.

## Surgery

Several types of surgical procedures are used in the treatment of breast cancer.

**Radical Mastectomy**

This was the most common form of treatment for breast cancer for many years. It was designed to treat much larger breast cancers that were common a generation ago. It is less often used today. The operation removes the entire breast, the chest wall muscles and the lymph nodes in the axilla (armpit).

**Modified Radical Mastectomy**

This operation consists of a removal of the entire breast and the lymph nodes in the axilla. The removed axillary lymph nodes are examined under the microscope for the presence of cancer cells. This information is used to determine if additional treatment is necessary after mastectomy. Modified radical mastectomy preserves the chest wall muscles and leaves a more favorable cosmetic appearance than a radical mastectomy.

**Simple or Total Mastectomy**

This operation removes the entire breast and is usually combined with a partial axillary dissection (the removal of a sample of axillary lymph nodes) for microscopic examination.

**Partial Mastectomy**

These operations are also called segmental excision, lumpectomy, and tylectomy. They remove the breast cancer and varying amounts of surrounding tissue but preserve most of the breast. They are almost always combined with axillary sampling and are followed by radiation therapy to destroy any cancer cells that may remain in the breast. Comparative clinical studies are under way to compare this approach with more extensive operations.

**Breast Reconstruction**

If your doctor has recommended a mastectomy, you may wish to discuss the possibility of reconstructive surgery before the mastectomy is performed. Breast reconstruction is the creation of a mound on the chest wall by implanting a silicone gel breast form beneath the skin of the breast; or the transfer of tissue from the back or abdomen to the chest wall under which a silicone gel form is placed. Many women feel that breast reconstruction makes them feel better about their appearance and permits a wider selection of clothes and swimming suits. In some instances, reconstruction can be done immediately, or it may be delayed for several months or years after the mastectomy.

Many insurance programs will now pay for the reconstructive surgery since breast reconstruction is recognized as an important part of the rehabilitation program for some women. Check on your own insurance coverage. The American Cancer Society now offers information about breast reconstruction as part of its Reach to Recovery rehabilitation program for the woman who has had a mastectomy.

### Radiation Therapy

In most cases of early breast cancer, when a partial mastectomy is done, it is followed by radiation therapy. Many doctors currently prefer to recommend mastectomy until more long-term results of lesser surgical procedures are available. Partial mastectomy and modern radiation therapy can result in a near normal-appearing breast. The radiation therapy is given over a period of five to six weeks and side effects are few. You may wish to speak with a radiation oncologist before deciding on your treatment.

Radiation therapy is also sometimes used following mastectomy. At one time, post-mastectomy radiation was recommended for many patients. At present, it is only recommended in special circumstances.

### Chemotherapy

Chemotherapy may be used after surgery or radiation therapy. If it is given shortly after the primary treatment, it is called adjuvant chemotherapy. Many factors are evaluated in making a recommendation for adjuvant chemotherapy, but the presence of cancer cells in the axillary lymph nodes is the most important. The purpose of the chemotherapy is to try to destroy any cancer cells that may have spread beyond the breast area not treated by local surgery or radiation therapy.

Chemotherapy may be given in the doctor's office or in the hospital. While it acts mainly on cancer cells, it has an effect on normal cells as well. Side effects are common and will vary depending on which drug is used. Duration of an adjuvant chemotherapy program varies, but usually lasts for six to twelve months.

The surgeon, the radiation oncologist, and the medical oncologist work as a team to develop and coordinate the best treatment program for you. No matter what treatment is selected, you should participate in the long-term medical follow-up program determined by your physician.

### Coping With Breast Cancer

The possibility or realization of breast cancer brings with it many stresses and concerns. You should feel free to talk about your feelings and concerns with your physicians, nurses, and social workers who have special training in helping a person cope with cancer or the threat of cancer.

You can take advantage of special services designed to help women with breast cancer. Your physician may be able to arrange a visit from another woman who has been treated for breast cancer and has been trained by the American Cancer Society's Reach to Recovery program. There also may be other support groups and self-help groups available in your area. You can seek a counselor through your physician or hospital. Information about Reach to Recovery, available literature, and a range of services can be obtained by contacting your local Unit of the American Cancer Society.

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